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The Journal of the American Medical Association

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WORK OF THE AMERICAN MEDICAL ASSOCIATION *

WILLIAM L. RODMAN, M.D.
President of the American Medical Association
PHILADELPHIA

In assuming the presidency of the largest and most important medical organization in the world, and at the time of its greatest achievements, I am overcome with humility and a consciousness of my own limitations. Profoundly grateful for so signal and unmerited an honor, I shall ask that the same partiality which placed your standard in my hands strengthen and support me until I shall have transferred it, unsullied and undimmed, into the hands of my successor.

With your help I may succeed; without it, failure is certain; therefore, grant it me in unstinted measure.

As the splendid work of the Association, carried on by its officers and several councils, has not been reveiwed by my immediate predecessors, it would seem eminently fitting that I should, at this time, attempt a retrospect of some of its most noteworthy achievements, and incidentally point out how, with your cooperation, other equally desirable results may reasonably and certainly be attained.

THE AMERICAN COLLEGE OF SURGEONS

As the American Medical Association always stands for altruism and noble endeavor, it is my first duty, as well as my great pleasure, to congratulate most heartily the officers, board of regents and fellows upon the auspicious beginning of the American College of Surgeons, its achievements and its splendid aspirations. It has already, in its brief existence, accomplished much in elevating the general tone and level of American surgery, and met all reasonable expectations of its sponsors. The college was organized to fill a distinct need, and its aims and purposes were well presented by its president, Dr. J. M. T. Finney, at the inaugural meeting in Chicago, in November, 1913, in an address which was notable for its ability, sincerity and lofty character. With a rare and keen discrimination, equaled only by the courage shown, he pointed out the weaknesses in our armor, and the professional obligation of all to overcome them. I cannot do better than quote some of his forceful words, and, further, to express the hope that every member of the profession, in or out of the college, will read and read again the entire address:

> The aim of this new organization and the reason for its existence lie in its disinterested and unselfish efforts to elevate the standards of the profession, moral as well as intellectual, to foster research, to educate the public up to the idea that there is a difference between the honest, conscientious, well-trained surgeon and the purely commercial operator, the charlatan and the quack; furthermore, that the term "surgeon" means something more than a suave manner, a glib tongue, a private hospital, a press agent, and the all too easily acquired diploma. The standardization of surgery is absolutely essential to guard the public against such as these, as well as to preserve the honor of the guild itself. So far as the public is concerned, it is necessary to protect it from the wolves in sheep's clothing, from those who would prostitute their high office for the purpose of gain; from the ignorant and the untrained; from those who by reason of the lack of surgical judgment and skill are incompetent. That such are present in considerable numbers in our profession, and that they continue to ply their nefarious trade in every community of any size, with reckless disregard of the consequences, unfortunately cannot be denied. Are we to sit idly by while the fair name and fame of our profession are being dishonored and defiled? Is there nothing that we can do to protect the public and ourselves? Our presence here this evening is an answer to these questions. The American College of Surgeons has been called into being as an active, vigorous, virile protest upon the part of the profession itself against this unhappy state of affairs.[1]

No one who impartially reviews the work of the college, conducted as it has been by officers and a board of regents of the highest personal and professional standing, can withhold from them a large measure of praise for unselfishness, devotion to the cause, and a very evident intention to be true to the highest ideals of the profession.

In every community men are operating who have no right to take human life into their hands. This does not apply to the general practitioner who, in an emergency, and to the best of his ability, operates in an attempt to save life, but to those who, for gain, undertake that which should be done only by the skilful surgeon. Surgery is a special science, extrahazardous in its nature, and hence the public has a right to demand of the surgeon the very highest physical, mental and moral equipment.

The positive stand the college has taken on fee-splitting alone more than justifies its existence. This evil has become intolerable, and a wave of protest is rising throughout the land which should, and we believe will, overwhelm the offenders. Reform is bound to come, and the public will surely take the initiative if we do not. In some states the legislatures have already enacted laws constituting fee-splitting a crime. But it is most undesirable that our problems and shame should be corrected by legislators who imperfectly understand the real conditions. Let us at once apply the axe to the root, make this nefarious

* President's address before the American Medical Association at the Sixty-Sixth Annual Session, San Francisco, June 22, 1915.

1. Finney, J. M. T.: American College of Surgeons, presidential address, delivered at the first convocation of the college, Chicago, Nov. 13, 1913.

practice impossible, drive from the surgical temple those who defile it, and let their names and methods be anathema maranatha. If there be those within the ranks of the college who are at this time tainted with commercialism, it was not so intended by the board of regents, and they will make short shrift of any one caught *flagrante delicto*. I hold no brief for the board of regents, but am acquainted with every one of its members, and am satisfied that the honor of American surgery is safe in their hands. Undoubtedly mistakes have been, and others will be, made. But shall we expect human prescience to do that which Christ Himself did not do? Did He not in selecting His disciples choose Thomas who doubted, Peter who denied, and Judas who betrayed Him?

COUNCIL ON HEALTH AND PUBLIC INSTRUCTION

The Council on Health and Public Instruction continues to investigate health conditions, to educate the public and to foster a sentiment that will force the enactment of health laws. We are better prepared today to prevent disease and to save life than ever before; but we need the confidence and intelligent cooperation of the people before the work can be satisfactorily accomplished.

The Council is in touch with the newspapers, and since the Press Bureau was established three years ago, has issued 164 bulletins for publication in 4,900 newspapers. These bulletins are made up of extracts and abstracts of editorials and original articles from THE JOURNAL, with occasional articles on popular health topics, contributed by prominent members of our Association, but published without signatures.

Popular write-ups on medical subjects are too often but garbled statements of medical facts. Yet the daily press wishes, and has a right, to publish what the people want to read. In Kings County, N. Y., a publicity committee has cooperated with newspaper editors in working out a plan for getting truthful reports of interviews on medical topics. This scheme has worked so admirably that the Judicial Council recommended to the House of Delegates the formation of such a publicity committee in every county medical society in the country.

Another plan of the Council is to unite all of the public health organizations into a national league. With this in view, it has suggested that the various public health organizations hold their 1916 annual meetings at the same time and place. Special societies, such as those for the study of tuberculosis, cancer, infant mortality, etc., might be made sections of this national league, which would be a great advantage to them.

The Bureau of Literature has circulated pamphlets on health topics, notably on cancer, which at this time is being given great attention, not only by our Association, but by the American Society for the Control of Cancer, by a cancer committee appointed by the Clinical Congress of Surgeons of North America, by the Cancer Commission of Harvard University, and by state and municipal commissions as well, all working to the same end, namely, the enlightenment of the public as to the early symptoms of cancer, the necessity for prompt surgical intervention and the danger of running after false gods.

Several speakers connected with this bureau have told me of the large and interested lay audiences they have addressed in different parts of the country, and I myself have had a similar experience in the states of Maryland, Virginia, North Carolina, Ohio, Missouri Illinois, Minnesota, New Jersey and Pennsylvania. I have also been assured by local physicians in the cities and towns visited by such lecturers on cancer that the results have been most encouraging, and in many instances have led to early operation where, without such knowledge, the patients might possibly not have been operated on at all. I believe that the Association has done, and can do, no better work. In addition to the agencies already named, the federal government, through the director of the census, announces a new departure which should be welcomed. When the 1914 returns come in from the United States registration area, they will be made the subject of a special monograph on cancer. The deaths will be classified under some thirty headings, instead of seven as heretofore, and according to the region or organ affected, which is the arrangement followed in the standard reports of the registrar general of England and Wales. While not germane to the cancer question, it is of interest to note that the government Public Health Service also has undertaken a new work in beginning a sanitary investigation of navigable waters, thus far confined to the Potomac, Ohio, the shores of the Atlantic and the Gulf. This promises to be of vast interest and benefit to the entire country.

Many committees have done admirable work, notably the Committee on Resuscitation from Electric Shock, who have issued a chart and booklet for use in electric lighting plants which is considered authoritative all over the world; also the Committee on Resuscitation from Mine Gases, a report of whose work has been issued by the federal government.

The Joint Committee with the National Educational Association has been engaged in a fruitful study of health problems in education which will give an impetus to sanitation in rural schools, hitherto much neglected.

The activities of the Medicolegal Bureau are still in their incipiency, and it must be admitted that on the question of public health legislation the profession is still at variance. Efforts have been made, for nearly half a century, to secure the passage of laws regulating the practice of medicine in the different states, yet we fail to agree on the most essential requirements. The Association is, however, now making a more scientific study of medicolegal questions, and has issued two pamphlets dealing with this phase of its work. Nothing, however, could be more unwise or undesirable than hasty or ill-considered legislative experiments.

PROPAGANDA DEPARTMENT AND THE COUNCIL ON PHARMACY AND CHEMISTRY

The Propaganda Department reports an increasing public interest in the matter of "patent medicine" frauds, and has issued more than thirty educational posters as well as lantern slides for popular lectures on this subject. Boards of health, clubs and newspapers are alike active in disseminating information to the public.

The aims of the Council and what it has accomplished have made an impression upon the medical profession of both England and Germany, and in the latter country an association with similar functions has been formed.

Naturally the work of the Council has aroused much antagonism on the part of pharmaceutic manufacturers and those journals which make advertising a specialty, and some drug firms have threatened the Council with

legal proceedings if it published anything concerning their products. Others have already begun legal action which is being vigorously resisted by the Board of Trustees. But it is gratifying to note that other firms whose preparations are really new and of therapeutic value have voluntarily submitted them to the Council for examination and endorsement. Drugs are accepted only after most careful investigation.

The Association now has in its laboratory three chemists who give their whole time to the analysis of medicines. The Council has attempted to distinguish between medicines good and bad. In addition to New and Nonofficial Remedies describing proprietary and new drugs which are deemed worth the consideration of physicians, it has published "Useful Drugs," which contains the really valuable drugs in our materia medica. This a number of the best schools now use as a textbook. Its labors, too, have materially influenced the teaching of materia medica and therapeutics. It remains, however, for the profession to set its ban on all proprietary medicines, if the only information concerning them comes from those who manufacture and sell them.

A few newspapers submit their medical advertisements to the Propaganda Department for its opinion before publishing them. Would that the so-called independent medical journals might follow their example, and seek an opinion before advertising outrageously fraudulent nostrums in their columns.

The medical profession should realize the inconsistency of its Council working to eliminate these products and some of its journals doing their best to perpetuate them. It is absurd for us to fight self-medication on the one hand and encourage it on the other. Can we not by concerted action either stop these obnoxious advertisements or refuse to countenance the journals that carry them?

COUNCIL ON MEDICAL EDUCATION

The Council on Medical Education was established in 1904. Conditions demanded its creation, as other agencies had proved inadequate to meet a situation which had become intolerable. The moral influence of this great Association was necessary to quicken and give vital force to what had long been good intentions or ambitious dreams on the part of other and smaller organizations.

Its work has more than justified its existence; for it has, in a decade, accomplished more in the way of regulating and elevating medical education than had been done in a century; and it has been able to do this without the slightest legal power, but solely by reason of the righteousness of its cause, the high character of its members, and the wide publicity given its recommendations and acts in a journal which goes approximately to 70,000 medical men weekly. No institution could resist, much less defy, the official acts of such a body.

The profession has given the Council most cordial support, and it cannot be said that schools have been irresponsive. Indeed, when one considers the chaotic state of medical education in the United States in 1904, and then views the situation as it is today, there is cause for felicitation all around — to the Council, to the profession of the country, and to medical institutions — for so happy a consummation could not have been reached without the hearty cooperation of all.

Truth to tell, there are outside influences which have been most helpful in this beneficent work, and to them all due credit should be given ungrudgingly. The Association of American Medical Colleges, the Federation of State Medical Boards, the American Academy of Medicine and the Carnegie Foundation have at all times cooperated cheerfully, zealously and effectively. But, after all, is it not to the greater credit of the Council that it has been able, largely through the tactfulness and diplomacy of its chairman, to make use of and coordinate so many forces for good, which, while working separately, as they hitherto had done, had oftentimes, though inadvertently, pulled apart instead of together? No one who has attended the annual meetings of the Council, Federation of State Medical Boards, and College Association, held on consecutive days, in the same hall, the members of each body having the privilege of debate in all, could fail to be impressed with the admirable team work thus far displayed. To have united these bodies for effectiveness called for the ability of a wise general, and to weld and hold them together may require the genius of a field marshal.

If mutuality is to be the watchword of all, the structure must, and will be enduring; but if one body insists upon conditions and standards which do not commend themselves as both reasonable and attainable throughout the whole country, there is danger of retrogression. We go either forward or backward; the former is usually difficult, requires time, and those who are to be successful must keep ever in mind the admonition, "They stumble that run fast."

When the Council was organized in 1904, it published, as an ideal standard to which it would gradually approach, the following:

(*a*) Preliminary education sufficient to enable the candidate to enter our recognized universities, the passing upon such qualifications by the state authorities.

(*b*) A five-year medical course, the first year of which should be devoted to physics, chemistry and biology, and such arrangements should be made that this year could be taken either in a school of liberal arts or in the medical school. Of the four years in pure medical work, the first two should be spent in laboratories of anatomy, physiology, pathology, pharmacology, etc., and the last two in close contact with patients in dispensaries and hospitals in the study of medicine, surgery, obstetrics and the specialties.

(*c*) A sixth year as an intern in a hospital or dispensary should then complete the medical course.

This goal has been reached, at least on paper; the ranks have been thinned, as more than a third of the schools are now *hors du combat*, and it is expedient to mark time for a while, and give those institutions which have approached the firing line at double-quick speed a chance to catch their breath.

There are many reasons why this should be done. In the first place, the standard is now as high as it should be for *all* of the schools of the entire country. An irreducible minimum has been reached, and should be honestly enforced — that is, as soon as it can be. There is, of course, no limit to a maximum that any highly endowed and exceptionally circumstanced institution may adopt for itself.

Second, the present standard of the Council (four years in an accredited high school, one year in the basic sciences of chemistry, physics and biology) is on a parity with that of Canada and Great Britain, and with European countries. What reason have we to establish a cultural standard in medicine higher than that imposed by older countries?

Third, medicine is not a thing apart, but only a link in the educational chain, and should be based upon and

correlated with the secondary schools, colleges and universities of the country. Professional education, in medicine at least, has advanced much faster than our general educational system has done. Would it not be logical, henceforth, to direct our efforts toward stimulating progress in secondary education until it shall have caught up?

To make my meaning clear: We demand a four-year high school diploma, and, in addition, one year in biology, chemistry and physics of every matriculant in medicine; and this, notwithstanding the fact that many of the states are poorly equipped with *good* four-year public high schools, and that some, though having recently acquired them, are as yet without graduates. But the very states without such secondary schools, upon which we depend for the necessary cultural knowledge as a prerequisite to the study of medicine, have from one to three medical schools drawing nearly all of their students from their own state. No one knows this better, nor has any one expressed it more clearly, than did Dr. Pritchett when he said:

> To enforce honestly a four-year high school requirement would call for great firmness and self-denial on the part of the medical schools [in the South]; but to require on top of this a year of college including the sciences and a modern language is to inaugurate anew a régime of compromises and makeshifts, and to substitute an imitation of education for the genuine thing.

Furthermore, the second requirement, one year in the sciences, is no better, if, indeed, so well complied with. The high schools, colleges and universities by no means agree as to the character, scope and extent of such course, and when it should be given. At this moment their differences could not be greater or confusion worse confounded.

Fourth, it is paramount that a man complete his professional training and begin to practice by the time he reaches 25. This must appeal to every one who views the situation from a practical standpoint. To be a nonproducer, a dependent upon some one else, at an age when men can be both productive and independent, is abhorrent to the American mind, as we are sensitive upon this point and a people of action rather than doctrinaires. Therefore, the Council should keep ever before it this essential fact, and other less important requirements should weigh as nothing against it. Furthermore, there is a way to bring this about without in any way curtailing either the secondary or professional training one must have. The fault at this time is unquestionably with the secondary, and not the professional end of it. We have agreed that a course in biology, chemistry and physics is a prerequisite to the study of medicine, but we do not agree at all as to where, how and when such a course should be given. At this time it is given in the high schools, in the colleges and in the universities, and, judging from the very recent report of the committee appointed by the Association of American Medical Colleges to investigate the subject, is taught as indifferently in one place as another.

In order to meet this condition, medical schools not connected with universities, and some that are, have been compelled to take over this work so that it may be properly correlated with medicine. It should be given, however, by a separate and distinct corps of teachers, and entirely apart from the work of medical students. This system, while educationally unsound, as we must admit, became a necessity because of the unsatisfactory courses given by the various secondary schools, colleges and universities throughout the country, and, moreover, the seeming unwillingness on the part of their representatives to modify their courses in any way, either for the convenience or benefit of those intending to study medicine subsequently. And yet, these same presidents, deans and other representatives of colleges and universities seriously advise us to add another year of university work, so that sufficient science shall have been taught the prospective medical student. Why should such a demand be made only upon American medical students? No other country makes it; why then should we? To spend an unnecessary year of one's life in obtaining cultural knowledge that is, to say the most, of questionable and uncertain value to him in his profession, is worse than a crime — it is a blunder. The literary colleges must at least improve their laboratories and tuition, so far as the sciences are concerned, before they can reasonably ask that one relatively fruitless year be passed within their walls; to double the dose would certainly be a serious handicap to the student and might be fatal to our educational system. The committee appointed by the Association of American Medical Colleges has this to say in its report:

> We are forced to the conclusion that the literary colleges over the country are not giving the science subjects demanded in our schedule in their first year's curricula, and, apparently, in many instances are not giving biology and physics as regular work for a bachelor's degree.[2]

If we add to this testimony that of President Lowell of Harvard and others who have read papers at the several conferences referred to, it is perfectly clear that there is no uniformity of practice or thought among the officials of colleges and universities, so far as the scientific course is concerned. Therefore, for the present at least, it must be taught largely by the medical schools, as has long been the custom in England, where the results are most satisfactory; or there must be as has been suggested by distinguished educators, a rearrangement of the curricula of high schools, so that they will embrace a course in the sciences which will be acceptable to medical schools. This, I believe, is the very best solution of the problem, as there is no good reason why a first-class high school should not give a boy such instruction whether he intends to study medicine or not. Many of the high schools do this now, and all might be induced to make the necessary change reasonably soon. In a recent conversation with the principal of the Central High School of Philadelphia and the head of the department of science, both expressed the opinion that boys leaving the high school should be fully prepared to begin the study of medicine. Both men are entirely familiar with our modern requirements, as they have kept in close touch with the situation at all times. Professor Keller, for many years head of the science department, has been kind enough to give me, in addition, his opinion, in a letter from which I am authorized to quote. He says:

> We are satisfied that the instruction now given in our scientific course fully meets the present actual requirements for entrance to the medical schools. The work includes a comprehensive course of instruction in science, including biology, zoology, physiology, physics and chemistry, as well as in two languages, either Latin and German, or French and German.

2. The members of the committee making this report are all connected with universities.

We can see no reason why the present requirements in biology, physics and chemistry should not be covered by the instruction given in any first-class high school, such as we have in the larger cities.

The reasons for giving this instruction in high schools are many. First, boys from 15 to 19 are at the very time of life when they are more interested in such a course than they would be later on at college or university, when they will, perhaps, have chosen their future vocations and wish to prepare for them specifically. Second, education is naturally a function of the state, and this is being realized more and more all the time. One has only to consult the reports of the commissioner of education at Washington to be convinced of the marvelous changes for the better wrought in a decade. In 1901 there were 8,210 secondary schools with 649,951 students, whereas in 1911 there were 13,268 such schools with 1,246,827 students.

Mr. Claxton, commissioner of education, suggests that the twelve years of elementary and high school, now grouped into eight years of primary and grammar school and four years of high school, be rearranged, making the course six years in each. Taking the seventh and eighth years as part of the high school makes it easy to begin departmental teaching in these grades, and to adopt the methods of teaching and discipline to the changing demands of the children. It also makes it possible to begin vocational education two years earlier than is now the case, which all must think desirable. Virtually nothing is lost in the primary school by such an arrangement, as teachers are generally agreed that the time spent in the seventh and eighth grades is nearly always, under the present plan, a period of marking time.

High schools change with surprising swiftness, even in the older states. What was last year a registered three-year high school in New York often becomes this year a registered four-year high school. During the past decade a steady stiffening of the requirements for admission has occurred. Only the better high schools have been able to keep pace with these changes and to meet fully these requirements. The whole system of secondary education of a state may undergo in half a decade a thorough reorganization and uplift; the State of Virginia offers an example.[3]

I quote again from Commissioner Claxton:[4]

Not only must the courses of instruction in all public schools be varied and differentiated to meet the varying needs of all the children of all the people, they must also be so adjusted as to give the information and training necessary for intelligent and successful employment in all standard occupations. Whatever is needed to be done for the welfare of society in city or state should be taught in the public schools, unless it can be taught elsewhere better and more economically.

Whatever may be the solution of the problem of vocational education, it is quite clear that two things should be held firmly in mind: (1) that all education is one thing and not many, and that vocational schools are an integral part of our common school system; that whatever may be the trade by which one makes a living, humanity and citizenship, with all their requirements, are common to all, and must be considered in the education of all individuals and classes.

In the state of Pennsylvania there were but 193 four-year high schools in 1904, whereas there are 353 reported in 1914 (of these, forty-three are in cities and 310 in counties). There are still more schools giving three and two year courses, it is true (383 of the former and 134 of the latter); but if the rapid evolution of the past decade continues, there will very soon be more high schools giving a four-year course than schools of lower grade.

Now, while high schools are undergoing such evolutionary changes, is the propitious time to make an appeal to them to arrange their curricula so as to include a liberal science course. This appeal should have additional weight because they are public institutions maintained for the advantage of all; whereas colleges and universities, being largely private corporations, are managed to suit themselves and their officers, and would naturally be less responsive to outside requests or influences. The advantages would be palpable and direct, mutually beneficial to state, municipality, secondary, higher and professional education. The state and municipality owe, and can perform, no higher duty than to furnish youths with the very best educational advantages, as all that they give in this way is thrice repaid in a quickened, higher and better citizenship. Perhaps the very best and most wholesome law which a state can enact is that making education compulsory, thereby, to a certain extent, taking the control of a child from its parents. If this right is both assumed and exercised, it should be carried out conscientiously, wisely and thoroughly, and the states, domestic and foreign, that have measured up to this obligation have secured results which have placed them far and away ahead of those which have not. In no other way can we explain the satisfactory state of medical, as well as other branches of professional education in Germany and France, for instance. There professional education is considered, as it should be, a part of a general educational system, and hence is built upon a solid foundation. The thoroughness of the German secondary school system is most admirable, and should be imitated by other countries. The French, however, have better solved the question of premedical education, which is, at the present time, the most important question awaiting solution in America. After leaving the lycée with a baccalaureate, one must, before beginning the study of medicine, take a scientific course for one year, which includes physics, chemistry and natural history. It is designated as the P. C. N. course. It is given under academic auspices, and not by the medical schools—a practice educationally sound beyond question—but the course is objected to by the teachers of medicine as being too general in its scope and not sufficiently correlated with medicine. It is, nevertheless, thorough, embracing lectures and demonstrations in the morning, and active, practical work in well-equipped laboratories in the afternoon.

In England the same distrust of college and secondary school training in the fundamental sciences, upon which medicine rests, has always been shown, and to such an extent that the Conjoint Board of London, representing the Royal Colleges of Medicine and Surgery, refuses to recognize and give full credit for any such course taken outside of a medical school. Subject, but not time, credit is given. A student from such institutions must spend at least six months in the first year of a medical school reviewing what he has already had, and going further in the basic sciences before he can enter the second year of a five-year course in medicine.[5] This action is made necessary by the rudimentary state of public, or what they call board school, education in England, and the unevenness of scientific instruction

3. Babcock, Kendric Charles: Bull. 29, U. S. Bureau of Education, 1913.

4. Report of Commissioner of Education.

5. Frederick G. Hallett, Secretary, Conjoint Board, London.

elsewhere than in medical colleges. It is thought to be the best possible solution of the problem for that country, at this time, by an able, experienced and impartial teacher who is thoroughly acquainted with educational matters throughout the world, and who is, moreover, an enthusiastic advocate of the French system wherever it is practicable.[6] So, even if it be maintained that many of the high schools will not, or cannot, give an entirely satisfactory course in the sciences, their students beginning medicine can be given subject but not time credit, as is done in England, by our medical schools. I am of opinion that the English plan, which requires that at least six months of the science course be repeated, has much to recommend it and gives better practical results than the French system. When a boy takes his scientific course in a medical school, he is already pursuing what is to be his life work, he associates with medical students, occasionally attends, and is, perhaps, inspired by, a clinic, and his work of the first year is properly correlated with that of the second; moreover, and this is of the utmost importance, he is away from the many distractions inseparable from the first year of college life, when it is not expected that he take matters too seriously, but drift with the current.

In the medical school it is intensive study; in the college extensive study. I believe intensive work is better for the professional man, whereas a more diversified and widely distributed course is better for the man of letters.

The suggestion of Dr. Pritchett and Mr. Flexner that the secondary schools of Germany should include a satisfactory course in the sciences is certainly, I think, as applicable to our public schools.[7] Commissioner Claxton has shown it to be not only desirable, but also feasible in the United States, where changes are being made so rapidly in our secondary schools. Therefore, the present is the opportune time to bridge the gap between the secondary and vocational school by bettering the former and permitting a youth to begin medicine, law, engineering or other vocation before he is 20. It will then be quite possible for him to have graduated from a medical school and to have had a year's service in a hospital by the time he is 25. Then, and then only, in my opinion, will we get the type of men for whom there is a demand in the profession. To require, as medical schools do today, that part of one's preliminary education shall be in a high school, where there is confessedly no average standard for all of the states, and another part in a college or university where no greater uniformity is to be found, is, to say the least, an anachronism. We are a young nation with no hampering restrictions and traditions to fetter and hold us back when the very life of our educational system is at stake. Either the high school system should be changed, as urged by Commissioner Claxton, so that the four-year course will embrace all of the English, mathematics, sciences and languages necessary for professional enrolment, or paper credentials, which are now of relatively little value, should be given up altogether, and men accepted as medical students only after passing the necessary entrance examination.

Practically all medical teachers agree that the greatest defect with students is, and always has been, the lack of an adequate knowledge of English. Mathematics, the sciences and languages are of great importance, unquestionably; but to understand, to speak and to write English correctly is of far greater importance, and should be insisted upon as paramount. It was undoubtedly wise for the Council to omit German and French as a requirement after 1914. In lieu of them, it should strenuously insist on a more thorough preparation of students in English, and suggest that it take the place of German, which was formerly advocated by the Council, is still being taught by many schools in the premedical year, and is insisted upon by the Association of Colleges. A student can learn but little of any language, of which he has known nothing previously, in one year; yet the same time given to the study of English, and the necessary emphasis put upon it at the very beginning of his professional career, would be most fruitful. Appearance, address and correct use of English must always be among a physician's best professional assets, and to be indifferent concerning any of them certainly does not make for success.

In 1903, at its annual meeting in New Orleans, the Association of American Medical Colleges enacted into law a recommendation which had been made the year previous by President Vaughan to the effect that all matriculants in medicine should have a four-year high school diploma. A committee had been appointed at the meeting in Saratoga, and reported formally on the recommendation at New Orleans.

I had then, as now, the distinguished honor of succeeding Dr. Vaughan as president, and used what personal and official influence I could summon to put into effect his recommendation, notwithstanding the fact that it was strenuously opposed by many of my best friends and the two faculties of which I was then a member. As there were only about one third of the number of high schools in 1903 that we have now, and most of them gave one, two and three year courses, and but few a four year course, it was thought best to make the new requirement effective after July 1, 1905, and to give the student the option of an examination in lieu of a satisfactory diploma. This postponement also gave schools time to discharge all outstanding obligations to their students who had matriculated under the former standard. Some of the present difficulties were foreseen, but there was not, and should never be, the slightest sectional discrimination in an organization that is national in scope. This may be proper on the part of states, but the Association of American Medical Colleges and the American Medical Association should legislate, and have always legislated for the entire country.

There is but little doubt that the action taken by the College Association in 1903, and by the American Medical Association since the creation of its Council on Medical Education in 1904, has done much to stimulate the high school system all over the country, improving those schools which did exist, and causing states without adequate high schools to establish them. The medical profession has always exercised a wide influence on our common school system, as thousands of its members serve on school boards throughout the country, have intimate contact with educators, and can exert a wholesome influence upon them. Now is the accepted time to do it, for there are evidences of unrest everywhere. I know that it exists in Philadelphia, and that the adoption of the suggestion of Commissioner Claxton for junior and senior high schools is now being actively agitated in that city.

It is clearly the duty of the Council on Education to have, and even to publish, a list of acceptable and unacceptable medical schools; but I agree with the

6. Flexner, Abraham: Carnegie Report.
7. Carnegie Foundation, Medical Education in Europe, 1912.

position taken by Dr. Pritchett, in his paper at the February conference in Chicago, that the simpler the classification the better, as fewer mistakes will be made and, therefore, heartier support accorded by all. Nice discriminations between wholly acceptable schools are unnecessary, serve no good purpose, will naturally be resented, and may lessen the usefulness of the Council. There is always danger of overdoing a good thing. For example, all will agree that the railroads of the country formerly needed regulation by state and federal government, so flagrant had been their offenses and shortcomings. But nearly everybody, certainly a majority, now think that zealousness in the best of causes went too far, and resulted in injury to the railroads, the country and the people. Hence the present reaction and undoing of much that was unwisely done.

Therefore, the Council abolished "A plus" from its classification. It is proper and feasible to distinguish between schools which are acceptable and those which are not. The former have the necessary all-time teachers, equipment and hospital facilities, the latter are wanting in all of them to a greater or less extent; hence there can be no honest and intelligent difference of opinion concerning them. But, when the Council undertakes to discriminate between high grade schools, mistakes certainly will be made, as Dr. Pritchett so forcibly pointed out; for men would be more than human if they did not use all honorable means to secure the highest rating for their schools, and resent that which seems a work of supererogation, needlessly discriminatory, and inviting criticism and opposition. But while I am very clear as to both the wisdom and expediency of the present classification, I am also of opinion that it is the duty of the Council to give full credit to schools — and to make it equally prominent in its reports — which maintain a different standard from its own, be it higher or lower; and, further, to express an opinion, not only as to the ability of a school to fulfil its pledges, but also if it is consistently doing so. Standards are worse than useless if they are not both honestly and fearlessly enforced, whether the offender be strong or weak. Let others, as the prospective medical students who are most concerned, know exactly what the country offers in an educational way, and precisely where they can get it — not where it is promised. Every one knows that the catalogues and other announcements emanating from schools cannot be absolutely relied upon, as they are oftentimes the specious plea of the advocate and partisan and, if accepted at their face value by prospective students of medicine, will prove in the end both disappointing and illusory. One will hardly go to a doting parent for an unbiased opinion as to the ability, beauty and virtues of a child, nor will one seek opinion concerning a pastor from one of his devoted parishioners. It is about as wise to expect all deans who write medical and other prospectuses to spend their time in criticizing their own institutions.

At the meeting of the Council, Dec. 28, 1914, a suggestion was made, to the effect that, in addition to and following the official classification, the Council should enumerate on a separate page all those schools which require a diploma before one can begin therein the study of medicine; on another page those schools which require two or more years of college work before matriculation in medicine; on still another page those schools which require one year of collegiate work, and, on a final page, those schools which require, in addition to a five-year medical course, a sixth year as intern in an acceptable hospital. The representative of the Federation of State Medical Boards, who was present, said that this arrangement would greatly facilitate their work. I again endorse the proposition, and hope to see it become operative.

A committee, of which President Vaughan is chairman, was appointed by the Council to report a plan by which clinical teaching can be made more effective and practical. On this committee are ten of the ablest and most experienced teachers in the country, and their final report, whatever it may be, must have great influence toward controlling clinical teaching in America. The preliminary report of this committee, presented by the chairman, was read and fully debated at the meeting of the Council in February. It was a most careful, conscientious and able review of clinical teaching, showing how hospitals connected with medical colleges could be so managed as to insure to students practical, and, at the same time, most necessary advantages. Questions of general hospital management, endowment and equipment were considered, as upon them, in large measure, efficient clinical instruction must depend.

THE NATIONAL BOARD

To meet a situation which, under our peculiar form of government, has resulted in hardship, and must, if continued, cause countless embarrassments, a national Board of Medical Examiners has been organized, and will hold its first examination in Washington in October. The character and scope of this examination will be such that no state ought to, and we believe none will, deny recognition, in the fullest sense, to those who pass it.

At the same time, I wish to make it absolutely clear that such a board will not, cannot and should not interfere with the several state boards. Such an examination is for the exceptional, not the average man. It is for the man who, while young, willing and able to pass it, does so with the hope that it may prove a good investment for him in case of business opportunity, ill health in his family, or other impelling reasons which may cause him to change his location. All of us have in mind sad examples of able, even distinguished, general practitioners and specialists, who, compelled to remove from one state to another, were estopped from practicing their profession. Laws have been made, and rightly so, to restrain the ignorant and designing from imposing upon those whom the state would protect. That the state should insure the people protection in so vital a matter by placing its stamp upon medical practitioners cannot be questioned, and there is but one way in which this may be accomplished with equity and justice to all; that is, by requiring an examination at the hands of a state board of examiners. That conditions in all of the states are much better than those which existed prior to the formation of such boards cannot be questioned, for medical schools were given their first shock and made to improve by state boards, years before the Council on Medical Education was created; but the great number of states in our Union, some still maintaining multiple boards, makes a uniform standard simply impossible. Indeed, the boards of the several states not only differ in standard one from another, but the two or three boards in one state may differ as widely among themselves. Yet these differences are not only natural but also to a certain extent commendable, although especially trying and vexatious to practitioners who must move from state to state.

For many reasons a national board with power to confer a diploma carrying with it the unquestioned right to practice in any state — indeed, to follow the flag — has always been desirable, though, as yet, unattainable under existing laws. But there is a way by which such recognition may be accorded to a carefully selected and representative board, entitled of right to the confidence of the entire country, without changing the law in some states, and with but slight and immaterial changes in others. Many states have already, quite properly, given rather wide discretionary powers to their boards of examiners and invested them with authority either to recognize, or to withhold recognition from, extrastate agencies, domestic or foreign. This rests entirely with these boards, and they are governed solely by the standard of the body whose credentials are proffered. If high, they may be accepted without examination of the applicant; if low, they are rejected, and if doubtful, the candidate must be examined. No other course is reasonable. In some states the law is mandatory, and compels the applicant for licensure to be examined, in prescribed fashion, whatever his qualifications or credentials.

It should be a simple matter to induce all of the states at once to recognize a national board whose only aim is to improve the existing situation, and remedy a defect in our law and form of government, provided such board give an examination equal in every way to that required by the most exacting state in the Union. If this be done, then it becomes the patriotic duty of the several states to recognize its licentiates, just as the provinces of Canada now recognize the examination of its national Board of Examiners. There identically the same relations exist between states and general government as obtain with us, and there states' rights and jealousy of the general government prevented for more than fifty years the creation of a national Board of Medical Examiners. For several years past Canada has had such a national board, everybody is pleased with it, and all wonder how they got along without it. The president of the board explained its workings to us fully at the annual Conference on Medical Education in 1914. Shall we do less than Canada? Shall our states be less generous to their practitioners than her provinces? I do not for a moment think so.

The past fifteen years have witnessed a remarkable change in sentiment on the part of the several states toward the federal government. Many things formerly viewed, and resented, as encroachments upon the powers of the states are now not only accepted, but also eagerly sought by them or their representatives in Congress, and consequently all have been bettered. In no direction has a proposed change in our practice offered more to, and taken less from, the sovereignty of states than a properly constituted national Board of Medical Examiners will do. It proffers much; it takes nothing.

If questions of health, quarantine, pure food, the sale of narcotics, laws controlling the destruction of migratory birds, the granting of national charters, etc., have been yielded by states to the federal government — all of which has recently been done — why should there be the slightest hesitation on the part of any state to recognize the act of a national board of examiners, when by so doing it does not in the least surrender either authority or dignity? Certainly such a body, representative of the entire country geographically as well as through its public services and its leading national medical organizations, would be entitled to the same consideration—it asks no more—that is accorded a state board.

The government, without any authority in the premises, has, through the Secretaries of the Treasury, War and Navy, assented to the service upon such board of the Surgeon-General and an associate from each of these departments; and, in addition, has promised that the government laboratories, hospitals and schools for instruction may be used by the national board in conducting its examinations. The combined resources of these three government services are more than ample to meet every demand; moreover, they will insure an examination of such character as we believe to be necessary, yet is impracticable where large numbers of applicants are examined in one building, within a prescribed time, and by only a few examiners.

With the resources available to the board, a number of men can be examined in the several laboratories, some may be given a practical examination in the hospitals, while others undergo written, and still others take oral examinations, or operate on cadavers, all at the same time, but under different examiners.

An executive committee of five members is perfecting details for the first examination, which will be held from October 4 to 11, and longer if necessary, and, presumably, will be similar to that of the Conjoint Board of the Royal Colleges of Medicine and Surgery in England. An advantage, and a very great one it is, to those passing this examination, is the fact that they may subsequently become members of the Medical Reserve Corps of either the Army or Navy, if they so desire, provided that they fulfil the requirements as to age, and pass a satisfactory examination. The government gains also by the enlargement of these corps, and is insured sufficient medical officers in time of war, riot, pestilence or other exigency. Therefore, as I have intimated, it is the patriotic duty of all to support a board which can contribute so much to the national government in time of stress. Those who recall the Spanish War will vividly remember the difficulties which beset both our Army and Navy in obtaining sufficient medical officers. Many of those accepted were far from being up to the standard of the services; this I know, and, having been asked a number of times to recommend young men for the Army, remember how difficult it was to get them. I frequently discussed the matter with the Surgeon-General's office, as well as with Col. A. C. Girard, who was chief medical officer at Camp Meade, where I visited him and sent a number of contract surgeons from time to time.

The National Board has adopted the standard of the Council on Medical Education of the American Medical Association, and, in addition, will require at least one year of service in an acceptable hospital. These requirements will be rigidly enforced; that is, an applicant must give satisfactory evidence of having had the following:

(*a*) A diploma from a high school of good standing giving a four-year course.

(*b*) A satisfactory course in science, embracing physics, chemistry and biology, of not less than one year.

(*c*) Four years in a medical school of A grade.

(*d*) At least one year as intern in an acceptable hospital.

The hospital year is required for two reasons. First, no one should practice medicine independently, how-

ever well taught theoretically, until he has had practical training under experienced men, and this can be secured only in a hospital. Some colleges require it before graduation, and some states demand it before licensure.

Second, I think it most desirable that those who pass the examination should have the option of becoming members of the Reserve Corps of the Army or Navy; but to insure this, all requirements must be met. A year's internship in a hospital is required by both the Army and Navy.

While the amount of the fee to be paid by each applicant taking the examination has not, as yet, been determined by the board, there is no doubt that it will be much in excess of that charged by state boards, yet less than the amount charged by the Conjoint Board of England (£42). In America distances are often great, which may, with some, add materially to the expense of taking the examination in Washington; and, over and above the fee paid the national board, every one must also pay the usual fee for registration in the state of his adoption. Recognition of one's qualifications to practice medicine and surgery, by a given state board, by no means absolves one from paying the customary fee, just as though one were examined. To be excused from examination is all that can be reasonably expected, and this must be considered a courtesy, not a right.

As to the personnel of the board, I can say that there will probably be fifteen members, several not having as yet been appointed. All sections of the country are to be represented. As at present constituted, the board consists of: Admiral William C. Braisted, Surgeon-General, U. S. Navy, chairman; Major-Gen. William C. Gorgas, Surgeon-General, U. S. Army; Gen. Rupert Blue, Surgeon-General, U. S. Public Health Service; Col. Louis A. LaGarde, U. S. Army, treasurer; Asst. Surg.-Gen. W. C. Rucker, U. S. Public Health Service; Commander E. R. Stitt, U. S. Navy; Dr. Herbert Harlan, representing the Confederation of State Boards of Examiners; Dr. Isidore Dyer, representing the Association of American Medical Colleges; Dr. E. Wyllys Andrews, representing the American College of Surgeons; Dr. Lewis B. Wilson, representing the Mayo Foundation; Dr. Victor C. Vaughan, representing the American Medical Association; Dr. William L. Rodman, secretary, representing the American Medical Association.

2106 Walnut Street.

Extermination of Sleeping Sickness on Prince's Island.—Portugal is rejoicing that the prompt and thorough measures taken by the national public health service have apparently stamped out sleeping sickness from its colony on the island do Principe, west of Africa, where it seemed to have established a permanent foothold. The glossinas have apparently been exterminated from the island, and the thirty uncured persons are isolated in a state hospital under the direct supervision of the public health authorities. The medical mission that has been in charge of the work has appealed to the central authorities to refuse admission to the island to persons and cattle from infected countries, and to require notification of every case of trypanosomiasis that may develop. Cattle raising should be restricted to the southern part of the island, and hog raising should not be allowed anywhere. The number of dogs should also be restricted. The commission did not limit its work to sleeping sickness, but instituted a general educational campaign in hygiene which the *Medicina Contemporanea* describes in detail.

THE NATURE AND TREATMENT OF BRONCHIAL ASTHMA*

ROBERT H. BABCOCK, M.D., LL.D.
CHICAGO

Until about five years ago, the nature of this distressing affection was a matter for considerable discussion. The very terms applied to it attest the uncertainty regarding its pathogenesis. Thus it was called bronchial, spasmodic, nervous and idiopathic asthma. The appellations "nervous" and "idiopathic" have reference to its obscure causation, while the terms "bronchial" and "spasmodic" denote rather an attempt to define its pathology, if, indeed, it possesses any definite pathology. By some writers the dyspnea was believed due to spasm, but even among these advocates, complete agreement did not exist. Hyde-Salter, Biermer and others argued in favor of spasm of the bronchioles, while Wintrich and Bamberger stoutly maintained inspiratory spasm of the diaphragm to be the condition responsible for the respiratory distress. On the other hand, Weber contended for a fluxionary hyperemia as the essential nature of the asthma. Then we find the Curschmann spirals or the Charcot-Leyden crystals advanced in proof of bronchiolitis as the cause, or rather as the pathologic condition present.

In the consideration of the etiology of this malady, it was believed that heredity played a conspicuous rôle, as shown by asthma in both parent and child. This was especially true in those cases which developed in early life. In all cases a marked nervous influence was believed to exist and to account for the development of the asthma in later years of life and in those asthmatics whose paroxysms were evoked by psychic or emotional impressions or by the wetting of the feet, as cited by Hyde-Salter. Then came the announcement by Hack and others that some cases of asthma were cured by operation on and removal of intranasal abnormalities, as spurs on the septum, etc. The relief afforded in such cases was accidental and led to no intelligent or scientific conception of the actual nature of the disease.

The treatment, accordingly, was purely empiric, and aimed especially at the relief of the paroxysm or at its avoidance. Atropin was vaunted by Trousseau, while potassium iodid was praised by others. For the relief of the paroxysms themselves, asthma powders, morphin, ether, etc., were employed without any intelligent conception of their mode of action aside from the belief that they overcame muscular spasm.

Such, in brief, was the unsatisfactory state of our knowledge and of our therapeutics of spasmodic asthma up to 1909. In that year, Auer and Lewis published an account of their experiments on guinea-pigs by the intravenous injection of fatal doses of horse serum or edestin, and of their discovery that death was due to asphyxia from inspiratory distention of the lungs. In short, it was found that anaphylactic shock in these animals manifested itself as a typical picture of bronchial or spasmodic asthma. Moreover, it was proved that the result was the same when the vagus nerve was cut, the spinal cord and medulla destroyed and powerful artificial respiration was instituted. That the lungs were acutely overdistended with air was shown by even small portions of them

* Read before the St. Louis Medical Society, Feb. 13, 1915.

floating on water and crepitating distinctly on palpation. The experimenters concluded, therefore, that the extreme distention of the lungs was owing to tetanic contraction of the circular muscles of the fine bronchioles and alveolar ducts, and that this muscular spasm was of peripheral, not centric origin. Lastly, it is noteworthy that they found that a hypodermic injection of from 0.5 to 1 mg. of atropin was capable of preventing death from a dose of the foreign protein which proved fatal in the controls.

The foregoing observations on animals called attention to certain facts reported of the effects of serum injections, for example, diphtheria antitoxin, on persons who were sufferers from what is known as "horse asthma." In several instances, persons who had been sensitive to emanations from horses displayed, on receiving the preparation of horse serum, alarming symptoms which in a few cases resulted in death. Accordingly, it was suggested by Rosenau and Anderson, S. J. Meltzer and others that bronchial asthma in human beings might be a phenomenon of protein sensitization, or anaphylaxis, as it is commonly called. Impressed by this suggestion, I studied cases of asthma from a different point of view and soon became an ardent advocate of this conception of the nature of this distressing complaint.

Some of the cases which I shall refer to seem to set forth clearly the applicability of this theory to the etiology of asthma; but let me now present some of the facts regarding anaphylaxis as stated by Victor C. Vaughan in his contributions to the relationship between protein sensitization and disease or immunity.

When a protein foreign to the animal economy enters the circulation, certain body cells generate a proteolytic ferment which attacks and destroys the invading substance. This holds true whether the protein be bacterial or some stable body as egg albumin, the pollen of plants, horse serum or the emanations thrown off from animals, etc. According to Vaughan, this foreign protein, whatever be its source, contains two principles, of which one is toxic and in large enough doses may cause death, while the other sensitizes the animal and is characteristic of the protein. If the protein be introduced at short intervals and is not of an overpowering amount, the cells of the host split it up successfully, and immunity is established. But if the protein be introduced a second time after a period of two weeks or longer, and if it be in a considerable dose, the phenomena of sensitization or anaphylaxis occur.

Furthermore, the proteolytic ferment generated by the body cells is specific for that particular protein which called it into being and for no other. Moreover, the protective cells are capable of generating proteolytic ferments against as many different kinds of proteins as gain access to the blood. Consequently, an animal may become immune against or sensitized to a number of foreign proteins. Again, the body cells appear capable of storing up for an indefinite time, perchance for months or even years, their specific proteolytic ferment, so that a person sensitized to horse serum, for example, in the form of diphtheria antitoxin, may display the phenomena of anaphylaxis on a second administration of the antitoxin or other serum years subsequent to the initial injection. Lastly, the cells of the parent which have generated or stored up a specific proteolytic ferment seem capable of transmitting to the offspring the sensitization of the parent. In this way can be explained the liability to asthma, for instance, observed in several members or several generations of a family.

Finally, it should be borne in mind that the atrium or focus through which a foreign protein may gain access to the animal body may be varied. That is, the avenue of entrance may be parenteral, as an infective focus in the nose, throat, mouth, abdominal cavity, etc., or it may be through the digestive tract. In the last case, the sensitizing agent may be introduced in the form of some article of food, as cheese, shellfish, etc. Ordinarily the protein of the diet is absorbed as amino-acids which are again reconverted into that particular form of protein capable of utilization as nutriment by the body cells. But if, through some defect in digestion, a protein, as of lobster, does not undergo complete solution into amino-acids, and some one of the intermediate products is absorbed, it sensitizes the individual. Then if, after a sufficient lapse of time, twelve days or more, the same article of food is eaten and again passes into the circulation before its complete conversion into amino-acids, it occasions the phenomena of anaphylaxis, as, perchance, urticaria or an attack of bronchial asthma. It is only in this way that we can account for a paroxysm of asthma after an unusually hearty meal or the indulgence in some particular article of diet.

So many and varied are the causes that excite or precipitate an asthmatic seizure that at first thought it may seem absurd or impossible to explain their action on the basis of anaphylaxis. There are few complaints that display such apparently puzzling vagaries. Thus, one asthmatic declared he was sure to experience an attack if he slept on a pillow of goose feathers. The sensitiveness of some sufferers to emanations from horses or cats is well known. Hyde-Salter enumerates among the exciting causes a wetting of the feet, sudden emotion of grief, as in one instance in which an asthmatic learned of the unexpected death of his wife, an indigestible meal, constipation, the appearance of the menstrual function, etc. In some cases the sufferer may be unable to ascribe his attacks to any special exciting cause. Again, there are some asthmatics whose paroxysms of dyspnea come almost periodically after intervals of practical freedom from the attacks of their enemy. In others, the dyspnea is never wholly absent, being associated with the evidence of chronic bronchitis and becoming intensified at times into typical paroxysms of asthma. The state of the latter patients is truly pitiable, and it is these that tax our therapeutic resources to the utmost.

If, now, spasmodic asthma is to be explained on the hypothesis of protein sensitization, then we must assume the existence either of a focus in the body from which the foreign protein is absorbed, or that at some period, perhaps in childhood, protein sensitization occurred or that sensitiveness to a special protein was inherited from a parent, whether the protein be thrown off by animal, fowl or plant.

It might very naturally be asked why one individual shows his protein sensitization by a paroxysm of asthma while another does not, but instead may develop urticaria. At first sight this difference in reaction seems to contravene the claim made for the anaphylactic nature of asthma, or that this lack of uniformity warrants the inference of some specific asthma-producing protein. One cannot account for this differ-

ence except on some such hypothesis as a neurosis or perchance inherited sensitization, notwithstanding the fact that the experiments of Auer and Lewis show asthma in guinea-pigs to be independent of any influence on the part of the nervous system. Certainly anyone treating an asthmatic sufferer must gain the impression that neurosis plays an important part in the complaint.

On the other hand, experience with autogenous vaccines seems to indicate that the anaerobic bacillus discovered in the sputum of the case to be cited is in reality the *causa peccans*. At all events, in all of my cases to date this organism has been found, and has seemed to be the agent which in the vaccines did the most good.

Various foci may be the source whence protein is absorbed. Nasal polypi are not uncommon in asthmatics, and are thought responsible for the dyspnea through reflex bronchial spasm or hyperemia. But how explain the connection on the same hypothesis between asthma and chronic cholecystitis? A physician who had suffered from asthma for sixteen years at length developed symptoms due to gallstones. Believing that this condition still further increased the injury to his heart likely to result from his asthma, he decided on drainage of his gallbladder. This was done successfully, and to the surprise of both patient and surgeon, was followed by a remarkable effect on his asthma. So long as drainage of the gallbladder was maintained, the physician was free from his old enemy, and for the first time in sixteen years was able to remain at home and pursue his practice during the winter. When, however, drainage was allowed to cease, the asthma returned, but in a less severe form. The present state of this patient is not known to me.

How can this be explained on any other ground than that of absorption of a foreign (bacterial) protein? The same explanation holds with regard to nasal polypi. They are symptomatic of chronic ethmoiditis, and their presence in the nasal fossae interferes with free secretion, and hence favors absorption of bacterial protein from the ethmoid cells or from the nasal passages. Their removal does the same thing as did drainage of the gallbladder. This is attested by the fact that radical operation on the ethmoid by curettage has been followed in more than one instance by marked improvement, if not cure of the asthma.

Whenever, as reported by Hack thirty years ago, asthma is lessened or cured by the removal of intranasal abnormalities, it is because better drainage is secured and protein absorption is prevented. In like manner, when Hyde-Salter observed asthmatic attacks to coincide with menstruation, it is not unlikely that some condition such as pyosalpingitis existed, and menstrual congestion interfered with drainage and promoted absorption of bacterial proteins.

We now come to the consideration that in cases of long standing there is quite sure to develop a chronic bronchitis which of itself gives rise to cough and dyspnea even when positive spells of asthma are not present. It is this condition which sometimes accounts for the failure of complete cure following many operations on the nose or accessory parts. When chronic bronchial catarrh exists, careful examination of the sputum by cultural methods discloses various and often numberless bacteria. So long as expectoration is free, absorption is hindered; but whenever cough tightens, ample opportunity is afforded for absorption of bacterial protein and for the phenomena of protein sensitization in the form of asthma. This is well shown by the following case, which illustrates also the sort of treatment likely to prove efficacious in accordance with our newer conception of the disease:

Last July I saw a man who had suffered from asthma for two years, and for two months had been confined to his bed. He was unable to lie down, and physical examination disclosed the typical picture of bronchial asthma: short and ineffectual inspirations with prolonged expirations, chest distended and filled with whistling, wheezing râles that were audible at some distance, a dilated right ventricle and tense, accelerated, somewhat arrhythmic pulse. Cough was difficult, and expectoration scanty and tenacious. Close questioning could elicit no history of a primary focus save that he had catarrh and one loose tooth. He was told to apply epinephrin ointment to the inside of the nose, and was given a prescription containing among other things tincture of lobelia and fluidextract of *Grindelia robusta*. A nose and throat specialist was sent to examine the upper respiratory tract, but no condition that might explain the asthma was found. Next his loose tooth was extracted, and disclosed a small alveolar abscess which was thoroughly evacuated. Vaccines were prepared from the pus of this abscess, but owing to neglect or misunderstanding were never administered.

During this time the man was not under my personal observation, but had been removed to a hospital, and was not again seen by me until late in September. The man had improved after the cure of the alveolar abscess so as to be able to get out on pleasant days, but still suffered with asthma every night. At this time the heart was not much dilated, but the lungs were still filled with numerous dry and moist râles of chronic bronchitis. Accordingly, it was decided to have cultures made from his sputum and vaccines prepared. Rosenow did this work for me, and reported a few fusiform anaerobic bacilli in preponderating numbers, but also pneumococcus, *Streptococcus viridans* and *Streptococcus haemolyticus*. The anaerobic bacillus emitted a somewhat offensive odor, and was believed to be the real offender. Nevertheless a mixed vaccine was prepared, and of this, 0.1 c.c., or 2 minims, was injected. When the man reported after three days for a second injection, he asserted that he had lost his nocturnal asthma after the initial dose of vaccine. In all, about twelve injections were given in gradually increasing doses at intervals of from three to five days, with the result that he not only experienced entire relief from his asthma, but his bronchitis had vanished and he declared he felt perfectly well.

Convinced as I am of the anaphylactic nature of bronchial asthma, the foregoing case seems to me to point the way to the successful management of many if not most instances of this hitherto baffling malady. The first step, of course, is the discovery and removal if possible of the focus from which the protein is absorbed when, as in the case just narrated, this exists in the body of the patient. If, as in some individuals, the asthma is evoked by emanations from an animal or other extraneous source, we can do no more than try to protect against exposure.[1] It is probable that most asthmatics have some abnormality within the nose, accessory cavities, throat or mouth. This defect either furnishes the foreign protein or, if in the nose, obstructs nasal secretions and so favors the growth and absorption of bacteria. Consequently all these possible foci, and especially the ethmoid and teeth, should be painstakingly examined by a competent and wide-awake specialist. If these parts, nose, sinuses, tonsils, teeth and jaws are negative, as proved if necessary by the Roentgen ray, then search should be made in all other parts of the body, and no possible source of

1. The establishment of immunity to horse serum or pollen of plants is being attempted and may yet become a positive therapeutic measure.

infection overlooked. A most minute inquiry into the history is often of the greatest value. Thus I recall a young woman whose asthma was found to have developed not long after what she called a cold, but which coryza had been attended by a profuse purulent discharge. This information led the way to a proper investigation, and a chronic ethmoiditis was discovered.

In some cases, it may be a chronic bronchitis or a patch of pulmonary fibrosis with atelectasis that is furnishing the bacterial protein. In such a case, or when operative procedure has not wholly rid the system of infection, a vaccine should be prepared from the sputum or other discharge, and injected under proper precautions. Some cases will yield readily to such treatment, but others may be met in which repeated cultures and vaccines will be required, for in some cases of bronchitis the chief offending germ may not be at first obtained. Such an instance, now under observation, has proved most perplexing and disappointing.

Perhaps, some one might say, treatment by means of autogenous vaccines may be all right, but what are we to do for relief of the paroxysms while vaccines are being prepared or until our exhaustive study of the case has revealed the original cause of the trouble? This is a proper question, since our therapeutic ingenuity is often sorely taxed. There are a few old and tried remedies which are now known to be antagonists to anaphylaxis and the action of which is explicable on this theory. Thus Trousseau almost a hundred years ago recommended atropin as a preventive, and, singularly enough, Auer and Lewis discovered that from 0.5 to 1 mg. of this remedy injected into guinea-pigs would mitigate or prevent anaphylactic shock from doses of protein that proved fatal in the controls.

Besredka, according to Vaughan, states that alcohol and narcotics exert transient and slight prophylactic effect against the symptoms of protein sensitization. This probably explains the short-lived freedom from an attack which some asthmatics find from whisky, as well as the prompt amelioration usually afforded by a hypodermic of morphin or heroin, etc.

Ten minims of a 1:1,000 solution of epinephrin thrown under the skin are in most cases highly efficacious, and probably possess transient antispasmodic or antianaphylactic power. Pyridin, ethyl iodid and the highly vaunted asthma powders act in the same way very likely, while at the same time they excite bronchial secretions. Tincture of lobelia, aspidospermin, ipecac and *Grindelia robusta*, or other expectorant remedies may be of service by promoting expectoration and thereby lessening absorption of bacterial protein when there is extensive bronchitis. A patient of mine was completely free from his asthma for three weeks after having been etherized for a tonsillectomy, but got his asthma again so soon as he contracted a coryza.

To my mind, no line of management offers so much promise of cure of this obstinate malady as does the administration of autogenous vaccines, in addition to the discovery and removal if practicable of the source of the protein absorption; but the rub comes in the detection of the focus or foci of infection. Patience is required on the part of both patient and doctor, and we should not hesitate to call in the service of experts in some special line of surgery, as rhinologists, in our aim at a thorough investigation and treatment of the case. Therefore, the initial step in successful management is a correct diagnosis.

77 East Washington Street.

THE TREATMENT OF INFANTILE PARALYSIS

PRELIMINARY REPORT, BASED ON A STUDY OF THE VERMONT EPIDEMIC OF 1914*

R. W. LOVETT, M.D.
BOSTON

In the fall of 1914, I was asked by the State Board of Health of Vermont if I would undertake on their behalf the treatment of the cases of infantile paralysis occurring there in the summer of 1914, of which there had been 293. A private citizen had given to the State Board of Health a certain sum of money to be expended on an investigation into the epidemiology of the epidemic and on the treatment of the affected persons. Dr. Simon Flexner of the Rockefeller Institute consented to take charge of the epidemiology end of the inquiry, and I embarked on the enterprise of the treatment of these cases in December, 1914.

The problem of the treatment of so large a group of cases was of itself a new and difficult one. The physicians of these cases were notified by the State Board of Health of certain centers where clinics would be held, and I made five trips to Vermont, spending two days at a time there, for the purpose of prescribing treatment. Cases were grouped in Burlington, Barton, Montpelier, St. Albans and Rutland, the local hospital in each instance being utilized for the purpose, and to each of these places I went with my senior assistant, Miss W. G. Wright, and investigated and prescribed for the cases by groups. Every possible facility was afforded to me for this investigation, and the work everywhere was made easy and agreeable by the interest and cooperation of the physicians and by the very efficient assistance of the State Board of Health.

There applied for treatment at the clinics 235 cases, but a certain number of cases of other years were brought for advice, and a certain number of cases of other paralyses were brought, cutting down the number of the 1914 cases to 149, and it is from these 1914 cases that the conclusions presented are drawn.

All patients were stripped, and the muscles were individually tested as to function. Cases in babies, which could not be examined in this way, are not included in the report. The muscles were classed as wholly paralyzed, partly paralyzed, and normal. By wholly paralyzed is meant that no response could be elicited from a voluntary attempt to contract the muscle either in a contraction of muscular fibers or tightening of the tendon.

The condition of each muscle was then marked on charts, which I originally obtained from Dr. E. A. Sharpe of Buffalo, and these charts form the basis of the following analysis.

NATURE OF THE PARALYSIS

It became evident that partial paralysis was much more common than total. Of 1,452 muscles affected, 416 were totally paralyzed and 1,036 partly, that is, the relation of partial to total paralysis was as 2.5 to 1. The ratio of partial to total paralysis varied in individual muscles, a matter to be discussed later.

A curious phenomenon was several times observed, where part of a muscle was paralyzed and the other

* Owing to lack of space, this article appears in THE JOURNAL in abbreviated form. Reprints of the complete article may be obtained from the author on request.

part not. This was observed in the deltoid muscle, where the anterior or posterior half might work independently of the other, and once in the pectoralis major, where the sternal and clavicular parts were separated by function.

The predominance of partial over total paralysis is of importance. The reason for it would seem to lie in the grouping and relation of the nerve cells in the anterior cornua of the cord. These cells lie

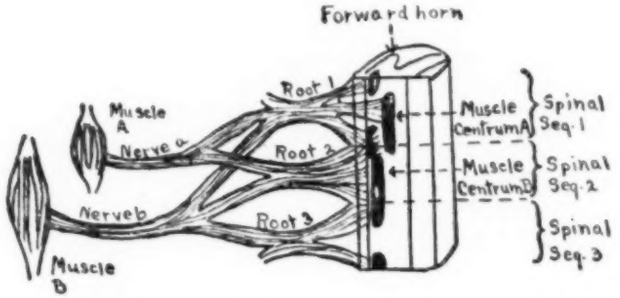


Fig. 1.—Radicular and peripheral muscular innervation. Muscle A supplied by segments 1 and 2; muscle B supplied by segments 1, 2 and 3 (Bing).

in longitudinal bundles, which are naturally largest in the cervical and lumbar enlargements.

I quote from Bing:[4]

> Each contains fibers from several anterior roots, and, conversely, each anterior root distributes its fibers among several peripheral nerve trunks. . . . Anterior nerve root lesions, on the other hand, unless very extensive, merely weaken and do not completely paralyze the muscle, owing to the fact that as a rule the muscle is innervated from several roots.

Moreover, we must remember that the poison of infantile paralysis apparently reaches the cord by means of the circulation, and that the main blood supply is from the anterior spinal artery, horizontal branches from which enter the cord at each side at different levels, about 200 in number. The planes of destruction, therefore, are likely to be transverse, while the lines of nerve center association are longitudinal, so that in the case of a muscle which derives its innervation from a group of nerve cells occupying several segments, a transverse lesion may well leave certain centers intact, and some power may remain in the muscle.

This matter of partial paralysis is most important in the matter of treatment, as we shall see when we come to discuss the therapeutic measure of muscle training, because in such muscles there remains some initiative, and with it the power of developing more muscular volume and new associations by repeated passages of impulses from brain to muscle.

AFFECTION OF INDIVIDUAL MUSCLES

A tabulation was next made as to the affection of individual muscles, which shows that they were affected either partially or totally in the degrees indicated in Table 1. This table gives the number of total paralyses of each muscle, the number of partial and total paralyses, and the proportion of total to partial in each.

The main facts are that the quadriceps, gluteals and gastrocnemius lead in frequency, and that paralysis of leg muscles is much more frequent than of arm muscles. Abdominal paralysis existed in more than half of all the cases (seventy-nine), and affection of the muscles of the spine in more than a quarter (forty). The latter points have a distinct bearing on the occurrence of scoliosis, and indicate, I believe, that such affections are more common than had been supposed. The cases of abdominal paralysis were always symmetrical with two exceptions, one right and one left. This paralysis may occur as the only

TABLE 1.—DEGREE OF AFFECTION OF INDIVIDUAL MUSCLES

Muscle	Number Paralyzed	Number Partial	Number Complete	Proportion of Partial to Total
Adductors	68	52	16	3.2:1
Gluteals	133	106	27	3.9:1
Flexors of hip	81	63	18	3.5:1
Quadriceps	152	119	33	3.6:1
Hamstrings, outer	97	66	31	2.7:1
Hamstrings, inner	95	73	22	2.7:1
Gastrocnemius	128	88	40	2.2:1
Tibialis anticus	119	53	66	0.8:1
Peroneals	96	40	56	0.7:1
Deltoid	57	45	12	3.7:1
Trapezius	49	42	7	6.0:1
Infraspinatus	17	8	9	0.9:1
Pectoralis	29	22	7	3.1:1
Biceps	31	24	7	3.4:1
Triceps	28	22	6	3.6:1
Abdominal	79	64	15	4.3:1
Latissimus dorsi	49	40	9	3.4:1
Spinal	40	36	4	9.0:1
Flexor carpi ulnaris	16	12	4	3.0:1
Flexor carpi radialis	16	11	5	2.2:1
Extensor carpi ulnaris	19	14	5	2.8:1
Extensor carpi radialis	18	13	5	2.6:1
Opponens pollicis	12	9	3	3.0:1
Extensor pollicis	23	14	9	1.5:1
	1,452	1,036	416	

paralysis in the entire muscular system. When associated with paralysis of other parts, the association is always with leg muscles.

The tibialis anticus and gastrocnemius are the only leg muscles which have been found to be affected by themselves without paralysis occurring elsewhere in the body. Of the former muscle, there were five

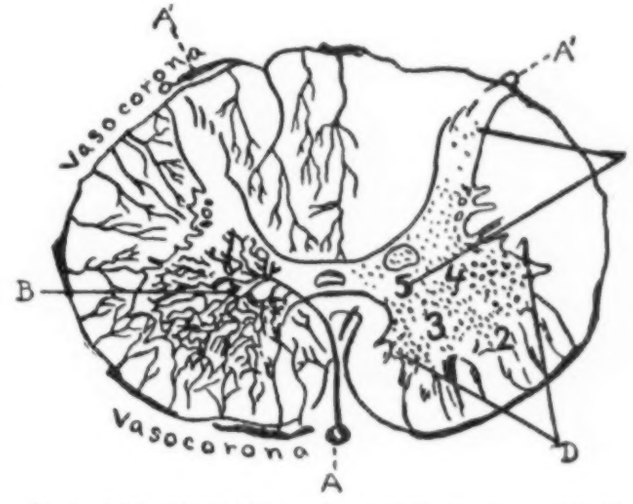


Fig. 2.—Distribution of blood vessels and nerve cells in the transverse section of the cord. *A*, anterior spinal; *A'*, posterior spinal; *B*, area of distribution of sulco-commissural artery; *C*, tract cells; *D*, root cells 1, postero-lateral; 2, antero-lateral; 3, antero-mesial; 4, central; 5, postero-mesial (Bing).

cases of paralysis, of the latter three. Deltoid paralysis may occur alone in the arm.

The investigation of paralyses of the arm showed (1) that the paralysis was most frequent at the shoulder and diminished in frequency from the shoulder to the hand; (2) that the paralysis was severest (that is, that the percentage of total cases

4. Bing, Robert: Compendium of Regional Diagnosis in Affections of the Brain and Spinal Cord, New York, Rebman Company, 1909.

was largest) in the shoulder and diminished as one went toward the hand, and (3) that paralysis of the muscles of the left arm was very much more frequent than of the right arm.

These three factors will be considered and tabulated, and then the leg will be considered in the same respects, after which the possible meaning of these phenomena will be discussed.

Other facts about paralysis of arm muscles are as follows: In cases in which the muscles of the upper extremity are involved without paralysis occurring at other parts of the body, it is more severe in this region than when the muscles of the legs are also involved; that is, arm paralysis which is strictly regional is more severe than arm paralysis which

TABLE 2.—FIGURES SHOWING THAT PARALYSIS OF THE ARM MUSCLES IS MOST FREQUENT IN THE SHOULDER AND DIMINISHES TOWARD THE HAND

Muscle	Total Paralysis
Deltoid	57
Trapezius	39
Pectoralis	29
Infraspinatus	17
Shoulder group	142 ÷ 4 = 35.5
Biceps	31
Triceps	27
Upper arm group	58 ÷ 2 = 29.0
Flexor carpi ulnaris	16
Flexor carpi radialis	17
Extensor carpi ulnaris	19
Extensor carpi radialis	18
Forearm group	70 ÷ 4 = 17.5
Opponens pollicis	23
Extensor pollicis	12
Hand group	35 ÷ 2 = 17.5

TABLE 3.—FIGURES SHOWING THAT PARALYSIS OF THE ARM MUSCLES IS SEVEREST AT THE SHOULDER AND DIMINISHES TOWARD THE HAND

Muscle	Total Paralysis
Deltoid	12
Infraspinatus	9
Pectoralis	7
Trapezius	7
Group	35 ÷ 4 = 8.75
Biceps	7
Triceps	6
Group	13 ÷ 2 = 6.50
Flexor carpi ulnaris	4
Flexor carpi radialis	5
Extensor carpi ulnaris	5
Extensor carpi radialis	5
Group	19 ÷ 4 = 4.75
Extensor pollicis	3
Opponens pollicis	9
Group	12 ÷ 2 = 6.00

exists in combination with more general paralysis. This statement rests on the analysis of fifty-eight cases.

With regard to paralysis of the muscles of the lower limb, the following facts were observed, which are of importance as contrasted with the similar observations in the arm:

1. The paralysis was on the whole more frequent at the hip, and diminished in frequency toward the foot; that is, the individual muscles in the upper segment were more often affected than in the lower (Table 5).

2. The paralysis was on the whole lightest in the hip, next lightest in the thigh and severest in the lower leg; that is, the proportion of total to partial paralysis increased as one went away from the hip toward the foot (Table 6).

RIGHT AND LEFT LEG

With regard to the relative frequency of paralysis in the right and left leg, the figures show in a total of 954 paralyses of leg muscles that there were 465 muscles paralyzed in left legs and 489 in the right, showing no especial difference in the affection of the two sides. This is a marked contrast to the predominance of left paralyses in the arm.

TABLE 4.—FIGURES SHOWING THAT PARALYSIS OF THE MUSCLES OF THE SHOULDERS, ARM AND FOREARM IS MORE FREQUENT ON THE LEFT SIDE THAN ON THE RIGHT

Muscle	Right	Left
Deltoid	24	33
Trapezius	18	21
Infraspinatus	6	11
Pectoralis	11	18
Biceps	11	20
Triceps	12	15
Flexor carpi ulnaris	7	9
Flexor carpi radialis	7	9
Extensor carpi ulnaris	7	12
Extensor carpi radialis	6	12
Extensor pollicis	5	7
Opponens pollicis	16	13
Total	124	189
Ratio	2 to	3 (very nearly)

TABLE 5.—FIGURES SHOWING GREATER FREQUENCY OF PARALYSIS IN UPPER SEGMENT THAN IN LOWER

Muscles	No.
Quadriceps	152
Gluteals	133
Gastrocnemius	128
Tibialis anticus	119
Outer hamstrings	97
Inner hamstrings	95
Peroneals	96
Flexors of hip	81
Adductors	68

TABLE 6.—PROPORTION OF PARTIAL TO TOTAL PARALYSIS IN THE MUSCLES OF THE LOWER EXTREMITY

Muscles	Partial to Total
Gluteal	4.0: 1
Quadriceps	3.6: 1
Flexors of hip	3.5: 1
Adductors of hip	3.2: 1
Hamstrings	2.7: 1
Gastrocnemius	2.2: 1
Tibialis anticus	0.8: 1
Peroneals	0.7: 1

ANALYSIS OF PREDOMINANCE OF PARALYSIS IN LEFT ARM AND FREQUENCY OF DISTRIBUTION IN ARM AND LEG

Certain interesting problems are opened up by this study of arm and leg affections which demand analysis. The facts of paralysis occurrence are as follows: The muscles of the limbs nearest the trunk are more frequently affected than the distal ones; the left arm muscles are noticeably more frequently affected than the right. The leg muscles in the right and left leg are equally affected.

The facts of use or function are that the right arm is much more actively used than the left, not only more frequently, but also for more varied and complicated and finer movements; the legs are used equally It would therefore seem that muscles used actively, continuously and in a complicated way were more likely to escape than those less used, or used for simpler, less continuous work. One would suppose that the blood supply would be more free around the spinal centers where the motor activity was greatest

and most complicated, and perhaps less free where the motions were less frequent and complicated. This would account for the predominance of left arm paralysis and the equal paralysis of both legs.

After these figures were worked out, it seemed that such a relation between right and left should appear more in older than in younger patients, because in the younger ones the differentiation between the right and left arms is of course less marked than in the older, younger children being much more nearly ambidextrous. If such a relation between right and left arms rested on a functional basis, it would be expected that there would be a larger proportion of left arm paralyses in older than in younger patients. In twenty-four patients 5 years old and younger, there were twelve left arms and twelve right paralyzed, a ratio of 1:1. In twenty-seven patients over 5 years of age (from 6 to 38 years) there were twenty cases of left arm paralysis and seven of right, a ratio of 3:1.

I should wish to acknowledge here my great indebtedness to Prof. W. B. Cannon and Assistant Professor Martin of the Physiological Department of Harvard University for much assistance on the physiologic side of the problem.

This also accords with the distribution of the paralysis in both arms and legs, which has been shown to be most frequent near the trunk. The demands on the hip and shoulder muscles are simple and less continuous than on the muscles of the lower leg and forearm or of the hand and foot. The latter are continuously active in small, fine, complicated movements, whereas the larger muscles nearest the trunk deal with the coarser and less frequent movements. The relation between the activity of the proximal and distal parts of a limb are not unlike those of the left and right arm in their relative use. It seems probable from these facts and this grouping that, on the whole, muscle centers given to finer, complicated, more frequent movements have a more active blood supply and are less likely to attack on their nerve centers from the virus of infantile paralysis than the centers of muscles functioning in heavier, less complicated and less frequent movements.

ANALYSIS OF SEVERITY DISTRIBUTION IN ARM AND LEG

In the next place, it has been shown that the muscles of the upper extremity are more severely affected nearest the trunk and less severely lower down, whereas in the leg this relation is reversed, and the largest proportion of severe paralyses is in the lower leg and foot. This is estimated on the proportion of total to partial paralysis in the individual muscles.

This puzzling phenomenon is more nearly correlated to the weight coming on each muscle in the activities of the upright position than to any other factor. The great majority of these patients were walking in some form or other, so that the weight-bearing position may fairly be taken into account.

At the shoulder, the deltoid, triceps and biceps all help to hold the arm up against the shoulder joint, and the weight to be met not only in this suspensory function, but also in attempted movements, is greatest at the shoulder and less as one goes down the arm, because the weight of the whole arm is obviously more than the weight of the lower one or two segments. Upper arm muscles, consequently, have more weight to handle than lower arm and hand muscles.

In the leg, on the other hand, the weight to be met in muscular function increases as we go from the hip to the feet, as of course there is greater superincumbent weight at the lower leg than at the hips, so that the lower leg muscles must raise more weight than hip muscles in walking, for instance. There is, of course, no proof that this variation in severity of paralysis is caused by this greater or less weight to be met in muscular function. The explanation accords with the facts, however, better than any other seems to do. Severity distribution cannot be connected with size of muscles, or function of a peculiar sort. It cannot be explained by local circulatory sluggishness affecting dependent parts. It is not associated with anterior or posterior muscles, nor is it easy to connect it with spinal localization. It seems purely a segmental limb distribution, and whether it is or is not the correct explanation, severity of paralysis is proportionate to the weight to be met by the muscles of the different levels, not because this factor influences in any way the original affection of the cells, but because it may retard the recovery of those muscles working against the greatest weight.

This suggestion has a direct bearing on the matter of treatment, for if it is correct it may be interpreted into showing the ill effects on muscular recovery of overuse, a matter which will be discussed later.

Infantile paralysis has been heretofore regarded as a haphazard affection of muscles, most frequent in the leg, and in the cord lesion it appears to have a purely accidental distribution most marked in the lumbar enlargement. It is possible, however, that there are other factors than the cord lesion which determine the ultimate condition of affected muscles. The analysis just made as to frequency and severity of paralysis shows that in cases some months after the attack there are apparently existing conditions not easily to be explained by the cord lesion alone, but suggesting that function, and especially the function of maintaining the upright position, may have something to do with determining the ultimate distribution.

ASSOCIATED PARALYSES IN THE LEG

Further pursuit of the inquiry suggested by the analyses just given takes up the question of muscular grouping in the leg. If the paralysis were a purely segmental affair wholly determined by the cord lesions, there would be in the limbs a roughly segmental distribution, muscles at the front and back of the thigh and front and back of the leg being more often paralyzed in this combination than in any combination suggesting associated function. In other words, opponents would be more often paralyzed in combination than would synergistic or functionally associated muscles at different levels.

The leg rather than the arm was selected for this analysis because of the greater simplicity of function in the former. In the arm, rotation movements complicate the more purely forward and backward movements of the lower extremity.

The inquiry then resolved itself into the investigation of whether associated or antagonistic muscles were most often paralyzed in combination in the legs.

The muscles in the leg most closely associated functionally are the gluteals, the quadriceps and the gastrocnemius, for they are the muscles which maintain the upright position. The gastrocnemius holds the tibia upright on the foot, the quadriceps holds the

knee straight, and the gluteals hold the trunk erect on the legs. The associations were as follows: If the quadriceps is paralyzed, either the gluteals or the gastrocnemius or both are almost always associated with it. In 109 cases there were only two exceptions. In three cases the quadriceps had no association in the leg. In the 109 cases of quadriceps paralysis, to contrast with the 106 associations of gluteals or gastrocnemius, there were only fifty-eight associations of paralysis of one or both hamstrings. The quadriceps, therefore, is affected nearly twice as often with its associated muscles as with its antagonists.

When the gastrocnemius is involved, the quadriceps or gluteals were involved in 108 out of 109 cases; but the antagonists of the gastrocnemius, the extensor longus digitorum and the tibialis anticus, either one or both, were paralyzed in combination with it in only sixty-six cases.

EXPLANATIONS OF PREDOMINANCE OF ASSOCIATION PARALYSIS

This predominance of association paralysis is susceptible of several possible explanations, of which the following may be mentioned:

1. The muscles which maintain the erect position are all very large, and must have large centers composed of many motor cells. On account of their very extent, therefore, they are more likely to be affected than smaller muscles by a generally distributed destructive process in the cord. That this is not altogether acceptable is shown by reference to Table 1, in which it will be seen that the tibialis anticus and peroneals, which are small, are of high incidence, and the pectoralis major, a large muscle, is of low incidence.

2. The second explanation is that associated muscles may be so intimately grouped in the arrangement of their motor centers in the cord that they are more likely to be involved in the same lesion than opposed muscles would be. If, however, one may trust to the present data on the segmental innervation of these muscles, this view is not borne out.

3. The third explanation for the predominance of residual paralysis in associated rather than antagonistic groups may be in the functional relation of the muscles themselves. Three muscles, the gluteal, the quadriceps and the gastrocnemius, work together to maintain the upright position, and if a whole leg is lightly affected, it may be that the association of these muscles in function may retard their recovery by their intimate and necessary functional dependence on each other; especially if one were seriously affected, it might retard the recovery of the muscles associated with it by throwing more work on them than they were able to perform in their affected condition, which condition would not obtain with regard to antagonists.

At this stage of the inquiry, it is not possible fairly to choose either one of these three explanations as the one to be accepted to the exclusion of the others.

CLINICAL APPLICATION

Such are the facts elicited in this preliminary analysis.

I regard one point as fairly well established by these figures, namely that there is another factor beside the plain anatomic distribution of the lesion in the cord which determines something of the extent and severity of the residual paralysis.

The therapeutic measures at our disposal in fairly early cases are massage, electricity and muscle training.

Massage may be expected to improve the local and general circulation, to facilitate the flow of lymph, and to retard muscular deterioration. It cannot, however, be expected to facilitate the transmission of a motor impulse from the brain to the muscle.

Electricity is less highly regarded in the treatment than was formerly the case. The unintelligent use of electricity month after month to the exclusion of other measures has been one of the handicaps which has stood in the way of the best progress in many cases. It is quite possible that it may improve the muscular condition. Statements of its value rest as a rule on bare personal assertion or on the unusually rapid improvement of individual cases; but cases vary greatly in their rate of improvement, and the only way to judge of the value of electricity is to use it on one side of the body in bilateral cases and use the other side as a control. In the winter of 1913-1914, some cases in private practice were given daily treatments of galvanic electricity on one side and none on the other, while daily muscle training was being given by my assistant, who was not told which side was receiving the electrical treatment. At the end of some months she was asked if either side had shown more rapid improvement than the other, and no difference had been noted. This simply confirmed my general experience of many years of less careful observation.

Muscle training, on the other hand, rests on a sound physiologic basis, works out empirically better than any other of the measures, and the large proportion of partial paralysis in the cases observed shows its reasonableness.

OVERFATIGUE AND OVERUSE

We come now to the final, and what I believe to be the most important part of the paper, namely, the possible effect of overfatigue and the overuse of massage on returning muscular function, a phase of the treatment question almost wholly neglected.

If we take the case of a partly paralyzed muscle with some remaining power, we are anxious to bring about in that muscle the greatest possible return of functional power; that is plainly our object of treatment. Now the rational exercise of a normal muscle results in increase of size and power of that muscle, and presumably the result would be the same in a muscle weakened by infantile paralysis which was rationally and physiologically exercised or massaged. We are, however, dealing with muscles in many instances very weak and incapable of doing much work, and it must be an easy thing to overexercise them.

As to the question of this overuse, the following facts are suggestive: The majority of the early cases seen in Vermont showed partial rather than total paralysis; the gastrocnemius muscle in cases of early paralysis was quite different from the stretched, lengthened and powerless gastrocnemius muscle of late cases. Muscles partly paralyzed in which power is returning may be rendered functionless by slight grades of overuse. These considerations all have a bearing, and in connection with observations to be mentioned, indicate the possibility that in many cases of infantile paralysis we are encouraging in partly paralyzed muscles a function wholly beyond their ability, and are thus delaying their return of power and possibly converting partial into total paralysis. The observations follow:

It has been repeatedly observed in my private practice that power might begin to return in a very faint degree to a muscle while under muscle training, and that with care this power would steadily increase, but if that muscle were exercised even very gently every day, that power would diminish or disappear, so that we exercise such muscles only once in three days at the outset, increasing the work most carefully.

A young man under my care, severely paralyzed in both legs, six months after the attack showed some return of power in the peroneals. This developed and was exercised in the usual way, but he was so delighted with the new function that one year after the attack he tried it at intervals all of one day on the principle that if a little exercise were good a large amount would be better, and the power promptly disappeared, never to return in full amount after some five months.

A young man with a paralysis of the left arm acquired in Vermont in September, 1914, was brought from New York to see me in December, 1914. He was having massage and exercises daily from an apparently competent masseur, and was urged to use his arm as much as he could to stimulate returning function; but for a month he had not improved, and the parents therefore decided to send him to me for treatment. He could not, however, come to Boston for a month, and asked what treatment he should pursue in the meantime. A sling supporting the shoulder was put on, he was forbidden to use the arm except at meals, and massage was stopped. After a month of this routine he showed at least 25 per cent. of increase of power.

I saw with Dr. F. B. Percy of Brookline, Oct. 19, 1914, a child of 10 with a total paralysis of the anterior tibial muscle and partial paralysis of the gastrocnemius. Ten days after the attack, sensitiveness had gone, but the child could only walk badly and unsteadily. She was kept quiet for a month more, when she was allowed to walk a few steps daily. She made a remarkable gain, and massage and muscle training were begun, Jan. 6, 1915, although the amount of walking was not increased to any extent, the child walking only a very little. In four months the gastrocnemius and tibialis anticus had apparently nearly normal power when their resistance was tested by the hand, but the child still limped a little. Feb. 24, 1915, four months after the attack, the mother was asked to keep this child practically off of her feet for two weeks while the other conditions of treatment were the same. At the end of this time the limp had disappeared.

Oct. 5, 1914, I saw a child of 5 with nearly complete paralysis of one leg below the knee from an attack three months previous. The child walked badly, but was much helped by a brace to hold the foot at right angles to the leg. Muscle training was started, and the child improved satisfactorily, evidences of returning muscle power becoming plain. March 6, 1915, the mother made a statement that attracted my attention, namely, that the child walked better in the morning than at night. She was asked to keep the child off of his feet as much as possible for a month, restricting walking to the greatest possible degree. April 6, 1915, examination showed during the month a very striking increase in power in the muscles controlling the foot, and it was evident that the progress in the last month had been far greater than in any previous month, and the child walked as well at night as in the morning.

These illustrative cases seem to me to show that much smaller degrees of overuse may be deleterious than is generally supposed. Probably any of us would agree that gross and persistent overuse of partly paralyzed muscles would be undesirable; but it seems to me reasonable that in the early stage of returning power, we should be exceedingly careful in the use of muscles in walking and in the use of heavy and prolonged massage, much more careful than we are at present, if I may judge the practice of others by my own previous methods.

I hesitate to reason from an unproved conclusion in this connection; but may I once more call attention to the fact that the proportion of total to partial paralysis is greatest in the muscles which have the greatest weight to oppose in the standing and walking position and least in those which have the least weight, in a series of cases observed some months after the acute attack. If overuse is the harmful factor that I believe it to be in retarding recovery, its effect would be noted in just those muscles which show the highest proportion of total paralysis.

234 Marlborough Street.

EXPERIMENTAL STUDIES OF VARIOUS ANTISEPTIC SUBSTANCES FOR USE IN TREATMENT OF WOUNDS

BASED ON THE WORK OF SIR W. WATSON CHEYNE*

ROBERT A. KEILTY, M.D.
AND
JESSE E. PACKER, M.D.
PHILADELPHIA

The purpose of this paper is the experimental study of the antiseptic power and diffusibility of various substances commonly used to check bacterial growth. The study is based on and largely follows the report of Sir W. Watson Cheyne.[1]

The study by Cheyne grew out of a desire to prevent sepsis in the wounds of soldiers received while on duty in the trenches and at the battle front during the present war. As a result of these wounds, an enormous number of serious infections have occurred, followed by a high mortality. This is due in part to a delay in reaching the base hospital and in part to the large number of wounded needing treatment at one time. It was Cheyne's idea that each man should carry a convenient package of some antiseptic diffused in a proper vehicle which could be introduced into wounds immediately after their occurrence, thus preventing or retarding bacterial growth locally, until a thorough disinfection could be carried out at a more convenient time and place.

In a later communication as a result of this work, the British government is now forwarding two packages to each man in the navy, one a paste made up of 20 per cent. phenol (carbolic acid) in a lanolin base and the other a powder of equal parts of boric and salicylic acids. A paste was chosen as a vehicle because of its ease in handling, because of the danger of liquids being lost and because of the fact that the recesses of lacerated tissues are more easily reached. Cheyne advised a paste composed of lanolin, 6 parts, and white wax, 1 part. This proved best from every point of view according to his experience. In our own work we have used this, and find one made up of castor oil, 70 parts, white wax, 20 parts, and spermaceti, 10 parts, to be equally advantageous, to diffuse a little more readily and to be considerably cheaper.

* From McManes Laboratory of Pathology, University of Pennsylvania.

* Read before the Pathological Society of Philadelphia, May 13, 1915.

1. Cheyne, W. W.: Lancet, London, Feb. 27, 1915.

The relative inhibitory, germicidal power and diffusibility of various antiseptics used and the most effective strength was determined by incorporating them into the base and growing bacteria on a slab of agar-agar over the paste. It was found that blood clot and agar worked equally well, and our work has been confined to agar.

The general scheme is to place the paste on the bottom of a Petri dish underneath the slab of nutrient agar, and to inoculate the upper surface of the agar with a bouillon suspension of bacteria. The activity of the antiseptic can be easily judged by observing the presence or absence and extent of growth on the surface of the medium.

TECHNIC

In order to obtain comparative results, conditions must be exactly the same for each substance tested. Hence 0.5 gm. of the antiseptic substance is used in each instance. This is spread on a coverslip three-quarters inch in diameter. Where drugs are to be tested in liquid form, two thicknesses of filter paper three-quarters inch in diameter are saturated with the substance, and the experiment carried on as with the paste. The agar slab must be the same thickness in every case. For this Edmund's chamber is used (Fig. 1). This consists of two glass plates, a brass ring one-quarter inch in thickness, a small portion of which has been removed, and three heavy paper clips. One plate is sterilized by passing through a flame and laid on a support, and the brass ring is flamed and laid on the plate, the open portion of the ring at one margin. The second plate is sterilized and placed over the ring. These are bound together with the paper clips. This forms a chamber open at one point into which melted agar is poured and allowed to solidify. When solid, the paper clips are removed, and the upper plate and brass ring lifted. This leaves the agar slab on the lower plate. The coverslip with the paste is placed on the center of the exposed agar, care being taken to have the paste next to the agar. The lower part of a Petri dish is inverted over the agar, and the Petri dish, agar and glass plate turned upside down. With a platinum rod the agar is easily transferred to the Petri dish. A tube of melted agar is poured around the slab to hold it in place. Finally the upper surface of the slab is inoculated by gently stroking with two loopfuls of a bouillon suspension of bacteria. The suspension is made by transfering two loopfuls of a twenty-four to forty-eight hour bouillon culture to a tube of sterile bouillon. This technic is that used by Cheyne with but slight modification for convenience. The plates are incubated for twenty-four hours at 37 C. (98.6 F), and the results recorded. The results remain remarkably fixed after the initial growth, even for days and weeks.

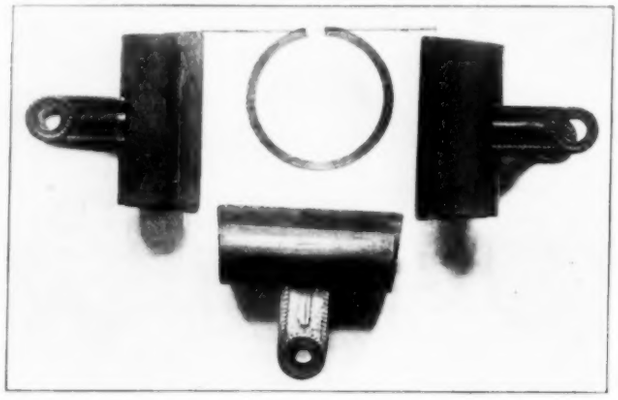


Fig. 1.—Edmund's chamber: a brass ring, two slides and three paper clips.

The organisms used in our work were the *Staphylococcus aureus*, *Streptococcus pyogenes* and *Bacillus coli*. It was found that substances inhibiting *B. coli* acted on the streptococcus to the same degree and on the staphylococcus to a greater degree, so that in most of this work *B. coli* has been used.

In comparative results the points observed include: 1. Is growth present and to what extent? 2. Is the growth directly over the paste? 3. How close to the margin of the paste does the growth extend? 4. What are the size and number of the colonies in relation to their distance from the paste?

From this comparison a convenient classification of the results may be given under three groups. 1. Those drugs which are markedly active. 2. Those drugs which are slightly active. 3. Those drugs which are inactive.

In order for a drug to fall under the first group, it must have not only antiseptic powers but also a wide range of diffusibility. The phenol group stands out preeminently, so much so that it is almost alone. Thus, too, the activity of the drug should be within a nontoxic dose as compared to common usage in an ointment, or as to its known absorbability in internal administration. Under the second heading drugs may be quite antiseptic locally, and yet according to this method show little or no diffusibility, except immediately over the paste, which means in distance a diffusing power of one-quarter inch through agar. Substances, for example, the dyes, may be quite diffusible and yet have little antiseptic power. If this range of diffusibility applies in vivo and the percentage of the drug used is carefully worked out, I see no reason why there is not offered a wide variety to be applied in the rational treatment of wounds not only in war but in civil life.

A summary of the substances tested follows:

1. Those drugs which are markedly active; under this we may include the following: tricresol, 10 to 20 per cent.; phenol, 10 to 20 per cent.; thymol, 10 to 20 per cent.; creosote, 25 per cent.; mercuric iodid, 10 to 30 per cent.; tincture of iodin, 5 to 10 per cent.

2. Those drugs which are slightly active: salicylic acid, 20 to 30 per cent.; Japanese powder, salicylic and boric acids, 20 to 30 per cent.; zinc chlorid, 20 per cent.; mercuric chlorid, 0.2 to 0.4 per cent. (in solution, 1:750, and 1:625); guaiacol ointment, 10 per cent.; mercuric ointment, 33 per cent.; creosote, 10 per cent.; carbolfuchsin (contains 5 per cent. phenol).

3. Those drugs which are inactive: iodin, 2 to 6 per cent. (crude drug); menthol and camphor, of each, 20 per cent.; boric acid, 30 per cent.; iodoform, 90 per cent.; zinc sulphate, 1 to 5 per cent.; alcohol absolute, alcohol methyl, alcohol, 95 per cent.; calcium chlorid, 20 per cent.; liquor formaldehydi, 0.1 and 0.5 per cent. (in solution 1:1,000, 1:500); lead nitrate, 5 to 10 per cent.; silver nitrate, 5 per cent. (in solution, 20 grains to 1 ounce); turpentine, 1 per cent.; ether, chloroform, Delafield's hematoxylin, sudan III, Loeffler's methylene blue, eosin watery solution; iodin green, glycerin, bismuth betanaphthol, 20 per cent.; salol, 20 per cent.; hexamethylenamin, 20 per cent.; zinc oxid, 25 per cent. scarlet red (2 per cent. scharlach R); bismuth subnitrate, 50 per cent; balsam Peru, ointment, 25 per cent.; scharlach R saturated solution.

It might be well here to include a little detail concerning some of the more important drugs. Of all the substances used, thymol and tricresol stood out prominently. This was noticed in two ways. They had a wide range of diffusibility, at the same time

inhibiting the active growth of those few colonies which formed. Alone they were both active, while in combination this activity seemed somewhat increased. Tricresol was used in percentages of 5, 10, 15, 20 and 25. It was noticed that with *B. coli*, for instance, in a 5 per cent. paste, a diffuse growth took place over the entire surface but much thinner over the paste; in 10 per cent., no growth over and one-quarter inch beyond the paste; in 15 per cent., very few and small colonies on the outer one-quarter inch of the agar; in 20 per cent., no growth. Thymol had about the same action, and possibly from all standpoints showed a little more activity.

Many combinations were tried, including phenol, creosote, thymol, salicylic acid, mercuric iodid and tricresol in varying percentages. Out of this group tricresol and thymol were selected as the best. Tincture of iodin (Fig. 2) gave the following: in 0.5 and 1 per cent., growth over the entire slab; in 2 and 4 per cent., up to the filter paper; in 5 per cent., one-quarter inch beyond the paper, and in 10 per cent., no growth. Crude iodin in 6 per cent. in paste failed to inhibit the growth over the entire surface,[2] but this solution contains only a small amount of iodin: about 0.35 per cent. Salicylic and boric acids, in equal parts as a dusting powder known as Japanese powder, because of its use in the Russo-Japanese War, in a 30 per cent. paste seemed to be quite efficient.

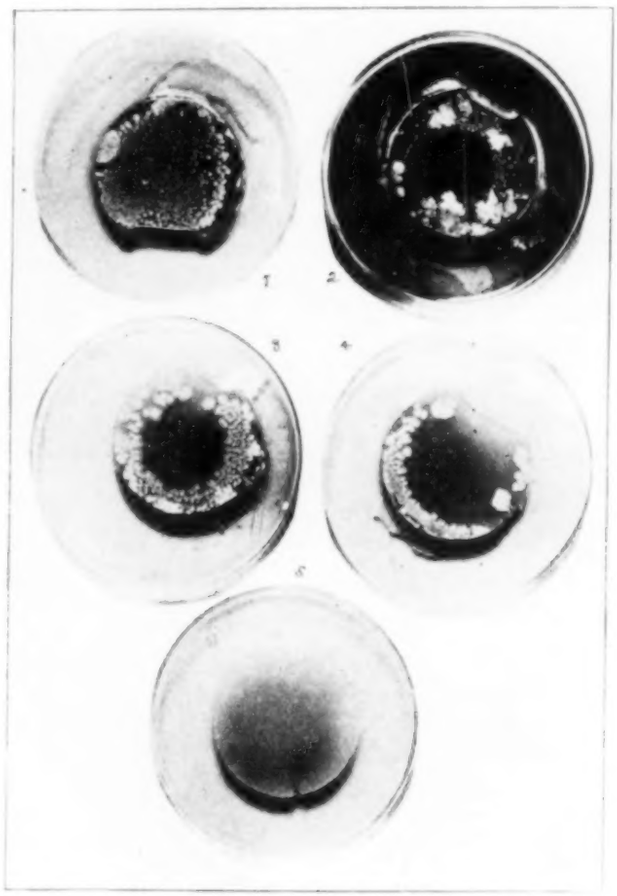


Fig. 2.—Tincture of iodin series: *1*, 1 per cent.; *2*, 2 per cent.; *3*, 4 per cent.; *4*, 5 per cent.; *5*, 10 per cent.

Those substances listed under the inactive heading in the percentages given all show diffuse growths over the agar slab. Silver nitrate, while it showed colonies over the entire surface, reduced the size of those colonies quite appreciably. Scarlet R (scharlach R 2 per cent.), a much used antiseptic, showed large colonies. Scharlach R in saturated alcoholic solution showed large colonies. Sudan III, an allied substance, showed quite an extensive growth.

From our experience, the following paste or ointment is recommended. Thymol and tricresol, of each, 10 per cent. in a base composed of castor oil, 70 parts, white wax, 20 parts and spermaceti 10 parts. Thymol and tricresol are more efficient in 15 and 20 per cent. pastes. They are recommended for use in 10 per cent. when infection has not taken place, or is superficial and not virulent, and in the higher percentages when the infection already exists or is severe. In the use of this paste, 1 dram of a 10 per cent. ointment represents 0.3 gm. or about 5 grains each of the antiseptic. Thymol internally in twenty-four hours has been recommended in dosage of 7 gm. in three hours (Wood). It is true that this is removed afterward by purgation. Pure cresol may be given internally in 2 to 3 minim doses (Wood). Cresol has the advantages of phenol with greater power, less irritation and lower toxicity. This statement may be open to criticism. However, we feel safe in recommending this ointment in dram doses of 10 or even 20 per cent. In the higher percentages, caution should be taken especially as to frequency of application. Since its object is a germicidal one, in these percentages one application should be sufficient with future asepsis maintained by less toxic substances. One of us has applied 1 dram of the 10 per cent. ointment, rubbing it well into the unbroken skin surface. There have certainly been no general effects and only the mildest local tingling. Examination of the urine before and two hours after the application showed no appreciable change in the sulphates.

2. In 10 per cent., mercuric iodid had a fair degree of diffusibility. Lugol's solution showed a growth over the entire surface.

CONCLUSIONS

1. The method as outlined by Cheyne offers an excellent means for the study, experimentally, of the diffusibility and antiseptic power of drugs.

2. The results obtained are confirmatory in some cases and startling in others as to the value of well-known remedies.

3. The phenol group and thymol give the best results as far as our work goes.

4. We are able to recommend an ointment composed of a base, castor oil, 70 parts, white wax, 20 parts, spermaceti, 10 parts, with tricresol and thymol, 10 per cent. each. Lanolin and wax may be used, but the vegetable base has some advantages.

5. These results are experimental, and must be borne out by clinical application. This we hope to do and report on in the near future.

6. The only drawback is the possibility of toxic effects, and this may be overcome by cautious usage in the amount applied and the interval between dressings.

7. This paste has a wide range in civil life as well as in war, and should prove more effective than those of common usage because of the increased percentages of the drug.

8. At the same time, the principle of the large dose is to establish at once or to maintain an asepsis in a wound, until ideal conditions for surgical treatment are available.

THORIUM—A NEW AGENT FOR PYELOGRAPHY

PRELIMINARY REPORT

J. EDWARD BURNS, M.D.
Assistant Resident Urologist, James Buchanan Brady Urological Institute, Johns Hopkins Hospital
BALTIMORE

In order that a solution may be ideally suited for use in pyelography, it must fulfil the following conditions: It should be nontoxic, nonirritating, and quite fluid, so as immediately to escape from ureters and bladder, and present the greatest possible degree of opacity to the Roentgen ray, casting not only a good shadow but also one of clear delineation.

Various colloidal solutions of salts of the heavy metals such as iron, silver, bismuth, copper and lead, and suspensions of the salts of bismuth, calcium and magnesium have been tried. All of these solutions sediment on standing, and while being, for the most part, quite opaque to the Roentgen ray, are viscous, and some are quite toxic and irritating.

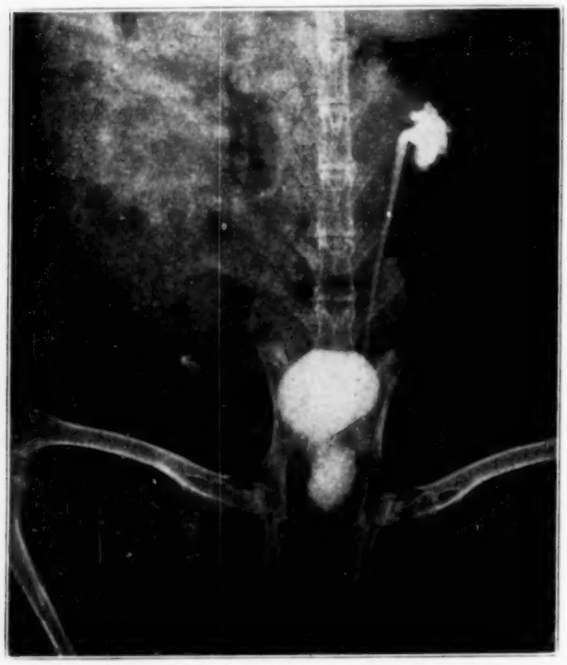


Fig. 1.—Rabbit's ureter and pelvis of kidney injected with 50 per cent. solution of thorium nitrate in distilled water.

Thorium nitrate dissolves readily in water, giving a clear, markedly acid solution, which, while being opaque to the Roentgen ray, is unsuitable for use because of its being an irritant, possessing a marked degree of astringency, and precipitating insoluble salts in the urine. This solution cannot be injected intravenously into animals because it causes intravascular clotting.

The neutral solution of thorium nitrate and sodium citrate, however, about to be considered, possesses, as far as observations made at the present show, all of the previously mentioned salient characteristics for use in pyelography. In this solution there seems to be a complex ion formation which changes both the chemical and pharmacologic action without causing any decrease of the opacity of the solution to the Roentgen ray. This solution also inhibits, but does not prevent the growth of ordinary bacteria. It flows readily, owing to its lack of viscosity, and escapes immediately from a ureteral catheter when injected into the pelvis of the kidney, or can be voided immediately if used in the bladder. It is perfectly clear to transmitted light, possessing a faint, yellowish tinge in large volume. It is perfectly clean and does not stain the clothing. From an economical standpoint, it

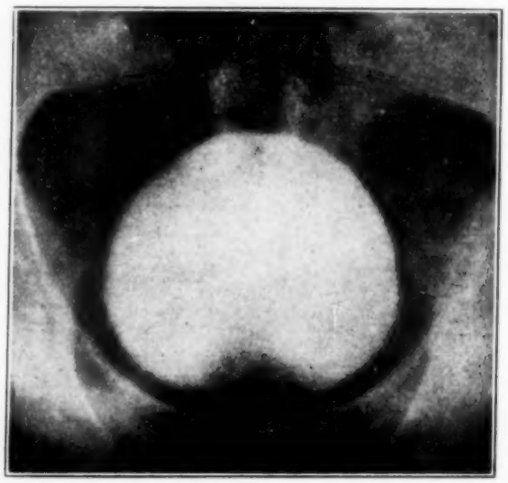


Fig. 4.—Normal bladder shadow. The bladder of this patient was injected with 350 c.c. of a 10 per cent. neutral solution of thorium nitrate and sodium citrate. Cystoscopic examination seventy-two hours after injection showed the bladder picture to be the same as before injection. The patient experienced no discomfort after the injection, nor where there any signs of irritation.

Fig. 3.—Trabeculated bladder with dilated internal sphincter, bilateral hydro-ureters and hydronephrosis due to congenital obstruction in the posterior urethra in a boy, aged 12 years. In this case, 600 c.c. of a 10 per cent. neutral solution of thorium nitrate and sodium citrate were allowed to flow in by gravity through a urethral catheter, the patient being in the Trendelenburg position while the picture was being taken. Cystoscopic examination, five days after the injection, showed the bladder picture to be the same as before injection. Phenolsulphonephthalein output and blood urea estimation were the same as before the injection. There were no signs of any irritative action.

has a decided advantage, being much cheaper than any of the silver preparations used at present, which are very expensive, particularly if used in quantities sufficient for bladder pictures and large hydronephroses. These preparations are also objectionable because they stain the clothing, have such viscosity as to make

Fig. 4.—Renal pelvis and ureter. Seven and five-tenths c.c. of a 15 per cent. neural solution of thorium nitrate and sodium citrate were allowed to flow into the pelvis of the kidney by gravity through a ureteral catheter. The phenolsulphonephthalein output was unaffected by injection; the solution caused no signs of any irritative action.

injections through a small catheter difficult, are very irritating when they escape into the tissues, and have, as a matter of fact, been followed by death in several instances.

The solutions used contain 10 per cent. and 15 per cent. thorium nitrate and are made in the following way:

To make 100 c.c. of a 10 per cent. solution, 10 gm. of thorium nitrate are dissolved in as little distilled water as possible; to this solution, kept hot on a water or steam bath, are added 30 c.c. of a 50 per cent. solution of sodium citrate, the additions being made in small quantities and care being taken to shake the solution thoroughly after each addition. At first after the addition of the citrate solution, a white gummy precipitate is formed which later becomes granular, and finally dissolves on the addition of all the citrate solution. This solution is then made neutral to litmus by the careful addition of a normal solution of sodium hydroxid, and made up to the required volume of 100 c.c. with distilled water. On filtration, a clear, limpid solution is obtained, which, when sterilized, either by boiling or steam under pressure, is ready for use. The stability of the solution is not affected in the least by sterilization.

The neutral solution of thorium nitrate and sodium citrate, prepared as directed above, is not irritating to the mucous membranes or peritoneal surfaces, does not precipitate salts in the urine, and can be injected intravenously up to 1.5 c.c. per kilogram of body weight and given by stomach up to 4 c.c. per kilogram of body weight in dogs without causing any change in the phenolsulphonephthalein output, blood urea content, hemoglobin content or cellular elements of the blood. No gastro-intestinal symptoms have been observed in any of these animals up to the present time. Complete protocols of these animals and further studies in regard to its pharmacologic action will be published in a subsequent paper. This solution may also be used in the roentgenographic study of the gastro-intestinal tract and other viscera.

The illustrations show not only the density of the shadow but also its clear delineation, when this solution is injected either into the bladder, ureter or pelvis of the kidney.

Further clinical studies are being pursued, and a report of their results will be published later; but the advantages of this neutral solution of thorium nitrate and sodium citrate for pyelography and other skiagraphic studies are so great that this preliminary report is now given. It is being used regularly in all our suitable urologic cases, and apparently is perfectly innocuous. If further experience confirms our present studies, it seems probable that we have in it a method of great value to urologists and roentgenologists.

SHORT CIRCUIT OF THE VAS DEFERENS

CHARLES MORGAN McKENNA, M.D.
Surgeon to St. Joseph's Hospital; Instructor in Genito-Surgery, College of Medicine, University of Illinois; Genito-Surgeon to People's and St. Bernard's Hospitals
CHICAGO

By short circuit of the vas I mean joining together the patent lumen of the vas with a section of the epididymis or testicle. Just a word regarding the anatomy of these parts in order to make the following clear.

The testis is composed of an enormous number of much convoluted seminiferous tubules, which fill up the intervals between the septums. These tubules form larger tubules, and finally make up the vasa efferentia, and on reaching the head of the epididymis form a larger tube which is called the canal of the epididymis. After a tortuous course, this ends at the globus minor and opens into the vas deferens. This is at the extreme lower pole of the testicle. The vas deferens begins at the tail of the epididymis and ends in the common ejaculatory duct, where it enters the prostatic or first part of the urethra.

Fig. 1.—Exposure of vas deferens; silkworm gut in lumen of cord.

The operation under discussion is usually done to repair an old gonorrheal epididymis in which there is an obstruction of the vas between the tail of the epididymis and the external inguinal ring. It is of the greatest importance, therefore, to know whether that part of the vas is patent between the external inguinal

ring and the opening of the ejaculatory duct into the prostatic urethra. This may be investigated at the time of the operation, but better should be done two or three days before the operation by drawing the vas through a small skin opening and injecting it with a solution of argyrol or collargol. By injecting the vas with either one of these solutions, the urine will become discolored a dark brown on first urination, hence, showing the vas between the incision and the prostatic urethra to be patent. If it should be found that the vas was not patent, it would be of no avail to do a short circuit operation, but Lespinasse's operation of the distal end of the vas becomes the one of choice.

Granting that the lumen is patent, the next point to be considered is the condition of the channel as to infection. It would be quite an error to go on with the operation if the seminal vesicle or ejaculatory duct contained any pathogenic organisms. I therefore wish to emphasize that it is quite important that the operator be absolutely sure that these parts are perfectly clean and will perform their duty if called on, provided one succeeds in opening the passage for the spermatozoa. If there is any doubt as to this condition existing in the seminal vesicle or ducts, these should be treated after Belfield's method.

Dr. E. D. Martin of Philadelphia in 1900 tried this operation with success. He used four fine silver wires for the anastomosis and used the head of the epididymis as the base for the implantation. This was done on each side at different sittings, and at the second operation succeeded in getting free spermatozoa in the urethra.

Scatudo in 1901 tried the same operation by doing an implantation of the vas into the rete of the testis. In his case, he did a complete resection of the epididymis, using the argument that if it were tuberculous, he could still get free sperm direct from the testis. One of his dogs escaped without an examination being made, and the others did not show any live sperm.

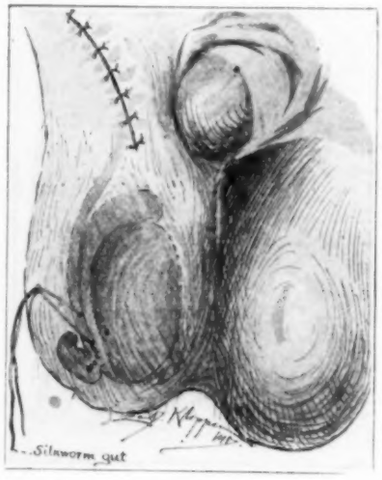


Fig. 2.—Anastomosis of vas with epididymis.

Boarri in 1908 reported a case in which he succeeded in getting the sperm through direct from the rete in the testis.

My own work has been done mostly on dogs at the St. Joseph's Hospital. This is more or less of a preliminary report on the work thus far carried out. In the first three dogs operated on, the incision was made over the vas in close proximity to the epididymis. The vas was divided at this point and brought in apposition to a section of the epididymis, the incision in the epididymis being made in the head. In the first three cases, ordinary catgut was used to make the anastomosis, and as a result no sperm could be found in the urethra. In the next three cases, two were done the same as the first, and in the third a fine silver wire was used instead of the catgut, which was removed later. In the case in which the wire was used, no trouble was manifested in finding free spermatozoa in the urethra. Before doing the next two, I consulted Dr. Belfield, who explained that, while he had never tried it or seen anything in literature, he thought it would be a good scheme to introduce a silkworm-catgut in the lumen of the vas, and draw it out through the skin. This was done, and I shall show later in the technic of the operation how it materialized. In the last two dogs operated on, a side anastomosis was done instead of the end of the vas being used as at first. The silkworm-catgut introduced in the lumen of the vas was not used as an anastomosing suture, but as a means to leave the lumen patent and remove any blood clot that might tend to obstruct the vas after the operation. This plan worked perfectly in all cases, even in one case in which the vas was crossed over to the opposite epididymis.

The work on man so far consists of six cases, five of which can be reported. Out of these five, two have passed living sperm, three have not passed any, and in the last one, sufficient time has not elapsed between the operation and the time of the writing of this paper. I feel that I am somewhat to blame for the nonappearance of the sperm in these cases. While there had been success with the operations performed on the lower animals, it is quite a different thing to operate on man when pathologic conditions exist. The error was made in doing the anastomosis, the head of the epididymis, instead of the tail, being always used. The selection of the portion of the organ to be used depends altogether with the operator. This may or may not be in the extreme tail of the body.[1]

It is not a good plan to do the anastomosis unless plenty of free motile spermatozoa can be found. Free spermatozoa cannot be mistaken by the naked eye when there are enough present. The appearance of sperm in the vas is that of white milky pus passing through blood. After a few observations there will be no difficulty in locating the best field for the implantation. But considerable time should be spent in locating a suitable section for the implantation, to assure the patient a fair prognosis. Thus far, I have had no difficulty in finding the motile sperm in the tail of the epididymis or one-fourth inch above the tail. In one of the cases in man in which operation was performed, the amount of sperm was so much that I was sure there must have been some pus still remaining in that section of the epididymis. Before the operation was completed, a slide was covered with the fluid and sent to the laboratory for diagnosis. Dr. George Dick made a microscopic report which showed the slide to be completely covered with living sperm. In this case sperm was found afterward in the urethra.

TECHNIC

I base my technic for short circuit or transplantation of the vas deferens on the contention that vas operations should follow out sound surgical principles as used in surgery in other parts of anatomy. Some of the important points are:

1. Clean exposure and fixation of the cord.

1. In one of the first cases reported in which the head of the epididymis was used for the implantation, the second and fifth nights after the operation the patient had an emission in which blood and argyrol were found in the discharge. This was certainly a proof that the operation was a success, and if free spermatozoa had been present they would have passed through.

2. The patency of the vas between the incision and the ejaculatory ducts. (This information is obtained by doing an injection of the vas previous to the present operation, Belfield's method.)

This operation is indicated when the occlusion is below the internal inguinal ring. The procedure is as follows:

The patient is cleaned and prepared as for any other surgical interference, except that tincture of iodin is not allowed to touch the scrotum in order to prevent excoriation. The patient is put under general anesthesia and placed in a slight Trendelenburg position. An incision is made in the same location as in operating for inguinal hernia and carried to the pendulous portion of the scrotum. The vas and epididymis are exposed at this point. A tenaculum or volsellum forceps are placed about the cord at its junction with the epididymis. A silkworm-gut is carried underneath the vas about 3 or 4 inches above the forceps. This is done to fix the cord in order that a clean field may be maintained, and makes the entrance to the vas easier for the operator.

The vas deferens is stripped of its covering for 2 or 3 inches above the epididymis by gauze dissection and Kocher director. Great emphasis is laid on this point as it expedites the operation and prevents any error in getting in its longitudinal axis in the lumen of the vas. An incision is made into the vas about one-half inch long. A fine pointed bistoury is the best instrument for this purpose. The incision is made about 2½ inches above the head of the epididymis. A piece of silkworm-gut is introduced into the lumen of the tube by means of a long hypodermic needle. The thread is put into the proximal end of the needle and pushed in just to the distal margin. The needle is now placed in the incision already made in the vas and pushed into the lumen of the cord above to the incision, and the point of the needle is brought out through the wall about 2 inches above the lower opening. The thread is drawn through the needle at this point, and the needle withdrawn through the lumen of the vas, thus leaving the silkworm-gut extending from the incision below and out through the wall 2 inches above, both ends of the thread being free. I wish to mention here that this is Dr. William Belfield's suggestion, and to him I wish to give all credit. Two sutures of chromicized catgut are placed through the incision already made in the vas and brought down into the opening made in the epididymis. The sutures are tied for permanent fixation, thus making the anastomosis of the vas with the epididymis and out through the skin, the sutures being tied loosely on the outside. These stitches are left in for from ten to fourteen days in order that the lumen of the vas may remain open. The tunica is closed in the regular way, as are the rest of the anatomic structures. The wound is healed and the scrotum put in a well-elevated position. The patient remains in bed from seven to ten days, at which time the skin sutures are removed.

The scrotum is carried in a suspensory from four to five weeks after the operation in order that no pressure be brought to bear on the anastomosed vas. Intercourse should not be allowed until six weeks after the operation.

CONCLUSION

I wish to emphasize the following points:

The vas should be free from infection.

The section of the epididymis used should contain plenty of free sperm, and the tail used for implantation.

108 North State Street.

Vital Statistics and Sanitation.—A nation that does not consider it necessary, or that is not able to provide adequate means for registering the births of its own children, or for officially recording the deaths of its citizens, can hardly be supposed to attach sufficient value to human life to enable sanitary measures for its conservation to be adequately carried out.—C. L. Wilbur, quoted by Irving Fisher, Memorial Relating to the Conservation of Human Life.

New Instruments and Suggestions

A PRACTICAL METHOD OF APPLYING THE WAX-TIPPED CATHETER IN THE DIAGNOSIS OF URETERAL STONE IN THE MALE

FRANK HINMAN, M.D., SAN FRANCISCO

It is barely three years since the valuable wax-tipped catheter method of diagnosis of stone in the ureter, introduced more than twenty years ago by Howard A. Kelly of Baltimore, for use in the female, was adapted by Burton

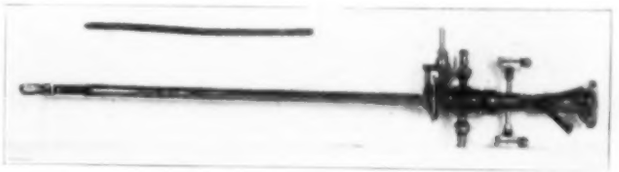


Fig. 1.—Preparation of wax-tipped catheter sheath: A soft rubber urethral catheter which will pass freely through the operating cystoscope (No. 9 or 10 F. for Brown-Buerger instrument) is passed into the cystoscope until the end projects a little beyond the elevator of the instrument. The other end is cut and slit up so that when the two slit portions are turned back over the mouth of the telescope they will hold the catheter in this position.

Harris for use in the male. The adaptation proposed (1912) by Harris has several objections: 1. The difficulty, trauma and pain of passing the cystoscope are increased. In the procedure the wax-tipped bougie is first passed into a full bladder, and the cystoscope, with its catheterizing telescope in place, is then threaded down the urethra over this bougie

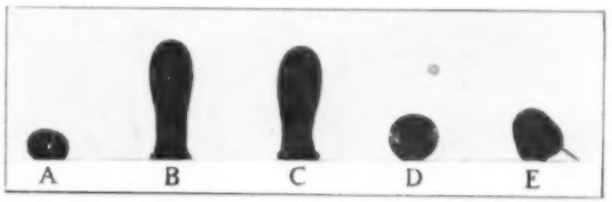


Fig. 2.—Method of making rubber tips for the operating telescope from small pipet bulbs: *A*, large rubber tip with single perforation on the market. This is too small for use with the rubber sheath; *B*, plain rubber pipet bulb, 3 cm. in length; *C*, bulb divided into three equal parts; *D*, first part placed inside of third and fastened with two silk sutures; *E*, single perforation in bulb, made with hot needle.

as over a filiform. Naturally the beak of the instrument must scrape along the catheter, and the window of the instrument, having no obturator, adds to the roughness and difficulty. 2. Security against scratching the waxed tip, whose position in the bladder is unknown on the insertion of the cystoscope,

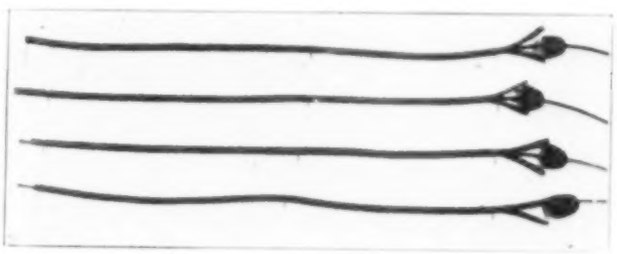


Fig. 3.—Rubber sheaths with wax-tipped catheters: In the upper two the tips are about 1 inch from the end, the position in which they should be, both for insertion of sheath into cystoscope and for withdrawal of sheath and catheter for examination of the waxed end. The rubber tip at the slit end of the sheath serves to mark and hold the catheter in this position. In the lower two the catheters have been pushed through for examination.

is not absolute. 3. The cystoscope must always be withdrawn from the bladder before the catheter is removed from the ureter.

A simple procedure, which overcomes these disadvantages, has been used recently in several cases with entire satisfaction. It eliminates completely the added difficulty and pain

in passing the cystoscope. It gives perfect security against extraneous scratches, and it permits the removal of the wax-tipped catheter for examination without previously withdrawing the cystoscope. The latter is a great advantage. Several control waxed tips may be passed one after the other, thus confirming the findings or accurately measuring the distance of the stone from the ureteral orifice. At the same time, and through the same cystoscope, an ordinary ureteral catheterization followed by functional study, ureteropyelogram or even both may be made, thus obtaining complete information in the case at the one cystoscopy.

Fig. 4.—Catheter sheath fastened in place by rubber tip. The elevator of the instrument has been raised, showing how the rubber sheath protects the waxed tip.

The operating cystoscope (Brown-Buerger is used, but the method is applicable with any operating instrument) is passed into the bladder as for ordinary cystoscopy, the obturator withdrawn, the bladder washed out (the irrigating fluid should not be too warm, as it may soften or melt the wax), and the operating sheath of the instrument then inserted. The wax-tipped catheter has been provided with a soft rubber sheath, which should easily pass through the operating barrel of the instrument, as shown in Figures 1 and 3. The usual rubber tip (Fig. 2 *A*) for the irrigating instrument is too small to cover the orifice of the telescope when the slit ends of the rubber sheath are turned back. A very satisfactory tip may be quickly made, as indicated in Figure 2 *B*, *C*, *D* and *E*. In fact, this tip will be found to be much more satisfactory for all work with the operating cystoscope than the hard, friable tips on the market. The method of passing the wax-tipped catheter is indicated in Figure 4. The sheath with its catheter inside (to within 1 inch of the end) is threaded into the instrument until the end of the sheath appears in the visual field just beyond the end of the elevator of the instrument. The slit portions of the other end of the sheath are then spread to the opposite sides and covered by the rubber tip, which thus securely holds the sheath in place and insures dryness. The waxed tip is now carefully pushed into the field (Fig. 5), the elevator, which strikes the rubber sheath and not the catheter is raised, and the catheter then pushed on up safely by the beak of the instrument into the ureter (Fig. 4).

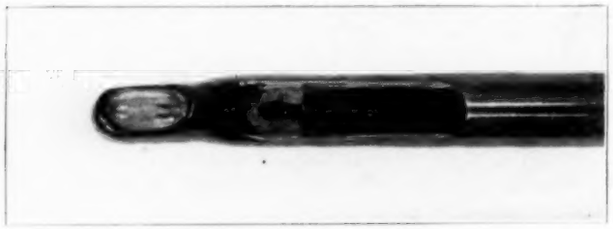


Fig. 5.—Waxed tip and rubber sheath before raising the elevator of the cystoscope.

In removing the wax-tipped catheter, after passing it up the ureter as far as desired, the lever of the instrument should be kept partially elevated; the waxed end can then be withdrawn into its sheath with no danger of striking the beak of the instrument. It is preferable to withdraw the sheath with the catheter in it, rather than to withdraw the catheter through the entire length of the sheath, for examination. In this way the waxed tip will have passed only a very short distance through its sheath, being originally retrograded into it to a distance of about 1 inch, and, before examination and after having passed up the ureter, not being withdrawn into it to a greater distance than this.

Physicians Building.

A NEW LID EVERTER

SIDNEY ISRAEL, M.D., HOUSTON, TEXAS

This small lid everter is the outcome of an endeavor to find an instrument that would give a large exposure of the entire upper lid and culdesac. Its most salient features are simplicity of design, ease of manipulation, and freedom from causing pain in introduction. It has been the means of revealing several cases of trachoma that had been overlooked by ordinary methods.

In introducing the instrument, it is grasped at its distal end between the tips of the thumb and index finger. With the patient looking down, the lashes of the upper lid are held in the tips of the thumb and index finger of the left hand. The knobbed ends of the instrument are then placed gently on the upper lid about one-half inch from the ciliary margin with the instrument in the vertical position. With the fingers of the left hand holding the lashes, the lid is retracted over the knobbed ends, and with gentle pressure on the distal end, the entire under surface of the upper lid, including the culdesac, is freely brought into view. In this position the knobbed ends can be slid from the outer to the

Fig. 1.—New lid everter.

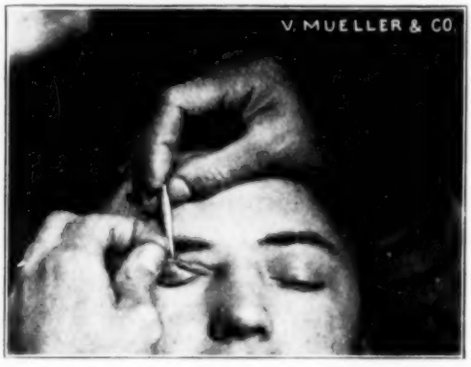


Fig. 2.—Method of using the lid everter.

inner canthus, exposing any part desired. In this position also, with the under surface of the lid exposed, the hold on the eyelashes by the fingers of the left hand can be released, and with the tip of the index finger of the right hand on the distal end still maintaining the position of the instrument in the vertical meridian, the thumb of the right hand can be dropped down to hold the lashes in place to maintain a complete eversion of the lid, while with the left hand free, any foreign body that is present on the under surface of the lid is easily removed.

The instrument can be readily carried in the pocket, and because of facility of introduction, can be used universally by the general practitioner and the ophthalmologist.

IMPROVED FORM OF BRAIN EXPLORER

HAROLD GIFFORD, M.D., OMAHA

In the *Laryngoscope*, January, 1914, I described a brain explorer consisting essentially of two knife blades held together with a spring, to be used in cases of suspected brain abscess in place of the exploring needle or scalpel. As is well known, each of the latter instruments may pass through the wall of an abscess, and either on account of thickness of the wall or thickness of the pus, may not reveal its presence. The practice of passing in dressing forceps and opening them here and there in the brain can hardly be called either accurate or elegant. With this brain explorer,

one passes the instrument into the brain as far as one thinks necessary, and then opens the blades; if no pus escapes, they are closed and passed on, being opened from time to time until they have gone as far as is permissible in any given direction. One can be sure after having done this that no pus in this particular tract will be left undiscovered.

Since my first article was published, I have modified the instrument, because on using it I found there would be a decided advantage in having the spring set off at an angle from the main axis of the blades. This greatly facilitates the introduction of a drainage tube or other drainage apparatus into the cavity of the abscess when the latter has been found. When the abscess has been penetrated and pus found, the instrument is kept in position until the drainage tube or gauze has been introduced into the cavity between the separated blades of the explorer, which have

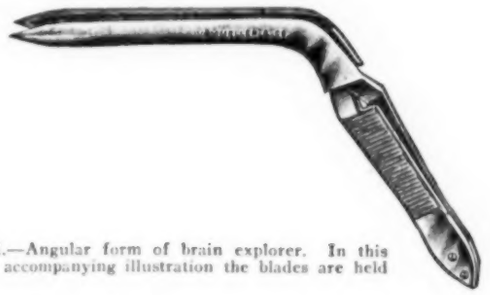


Fig. 1.—Angular form of brain explorer. In this and the accompanying illustration the blades are held apart.

been grooved on the inner side to facilitate the introduction of a glass tube. The opening in the abscess wall can be enlarged to the desired extent by the closed blades of the explorer, or, if preferred, this can be done with a blunt-pointed bistoury introduced between the blades.

Since I first described the explorer, I have had occasion to use it in three cases of brain abscess. In two of these it worked most admirably. In one of them, the abscess was deeply situated in the frontal lobe, and it is a very open question whether the ordinary instruments would have opened it successfully. This patient on account of disagreement with the internist in charge, passed out of my hands to that of another surgeon, and what the final outcome will be, remains to be seen. Another patient with a large temporo-sphenoidal abscess is now, after three months, apparently perfectly well. In the third case, the abscess was a very small one originating apparently from the sphenoid cavity,

Fig. 2.—Form of explorer suitable for entering the floor of the brain through the mastoid wound.

and was situated so far back, and so close to the median line, that although a careful search was made for it, it was missed, and the patient died.

In speaking of this instrument, which I have had in mind for a number of years, I have always said that the principle of it was so obvious that the idea must certainly have occurred to many operators beside myself, and I have found since my paper was published that West and Scott of London, in their excellent book on aural surgery (Blakiston's Sons & Co., 1909, p. 106), figure an instrument which they call an expanding trocar, which is made to be used in the same way. This, however, has such narrow, short blades that it must be decidedly less effective than the explorer here shown.

Beside the angular form of explorer (Fig. 1), I have had one made with curved blades (Fig. 2) for use on the floor of the brain. This form enables one to enter the temporo-sphenoidal lobe through the mastoid wound much more readily than could be done with the straight blades.

A COMBINED STAINING METHOD FOR MALARIAL PARASITES AND BLOOD SMEARS

FREDERICK F. RUSSELL, M.D., ANCON, CANAL ZONE, PANAMA
Major, Medical Corps, U. S. Army

In this country the most popular blood stain is Wright's modification of the Romanowski method; in England and the English colonies, Leishman's stain is used almost exclusively, while in Germany, Giemsa's is the favorite. These stains and their many modifications are all excellent for chromatin, but as ordinarily used they fail to bring out the cytoplasm of the malarial parasite with the sharpness and distinctness obtained with Manson's borax methylene blue. The latter, until the Romanowski was simplified by Leishman, Wright and others, was the best we possessed for malarial parasites; in fact, for routine work it is still used by many.

The advantages of Manson's stain may be briefly stated as follows: 1. Cheapness, permanence and simplicity of preparation. It is made by dissolving 5 gm. of borax in 100 c.c. of boiling water and adding 2 gm. of methylene blue, medicinally pure; when cool the volume is made up to 100 c.c. and the stain is ready for use. 2. The clearness and distinctness with which it brings out the cytoplasm of the malarial parasite. 3. The rapidity and simplicity of the staining technic. The smear is fixed for a few moments in equal parts of alcohol and ether, or methyl alcohol, and allowed to dry; it is then immersed in a very dilute solution of Manson's stain for from ten to thirty seconds, washed in water and dried. 4. It also shows well the basophilic degeneration of the erythrocytes.

Its disadvantages are that: 1. It fails completely to show the nuclear chromatin of protozoal parasites. 2. It fails to bring out the granulations in the leukocytes. Because of these two defects, Manson's stain has fallen into disuse in this country in spite of the fact that it stains the cytoplasm of the malarial parasite better than any other.

The disadvantages of the methyl alcohol stains of Leishman, Wright, Hastings and MacNeil are: 1. Their expense; it requires approximately 1.3 c.c. for each slide, and methyl alcohol of proper quality is costly. 2. The rapid evaporation of the stain on the slide, with resulting precipitation; this is especially troublesome during the windy season in the tropics. In Vera Cruz, for example, it was difficult to obtain clear preparations unless the slide was protected during the staining by a bell jar. 3. Great care and watchfulness are necessary to success in staining. 4. With none of these stains is the cytoplasm of the malarial parasite so clear and distinct as with Manson's stain. The stain of Giemsa belongs to this class, although it is used in aqueous solution; it is slow, expensive, practically impossible to obtain except from Gruebler in Leipzig and while it gives excellent chromatin stains, the cytoplasm is not well brought out.

The advantages of the methyl alcohol stains are: 1. The rapid and perfect fixation. 2. The clear and beautiful staining of the chromatin of the nucleus. 3. The production of Schuffner's dots in the erythrocytes in tertian malaria. 4. The beauty and distinctness of the nucleus, cytoplasm and all classes of granules in the leukocytes. 5. The distinct staining of the blood platelets.

It is evident that an ideal picture would result if the best of the methyl alcohol chromatin stains could be combined with Manson's cytoplasmic stain. After several attempts the following method was found to give the best results and it has been used for the routine of the laboratory for thousands of blood preparations:

1. Fix and stain for two minutes in Wright's or similar methyl alcohol stain. It is most convenient and economical to use about 50 c.c. of stain in a Coplin jar; the top should fit well to prevent evaporation and the stain may be used repeatedly.

2. Without washing, transfer the slide to a glass of tap water for from three to five minutes.

3. Without washing, transfer to diluted Manson's stain for from twenty to forty seconds. One-half c.c. (7 drops) of Manson's stain to 50 c.c. of tap water in a Coplin jar gives

about the proper strength. This staining fluid in concentrated form keeps well, but the diluted stain should be freshly prepared each day.

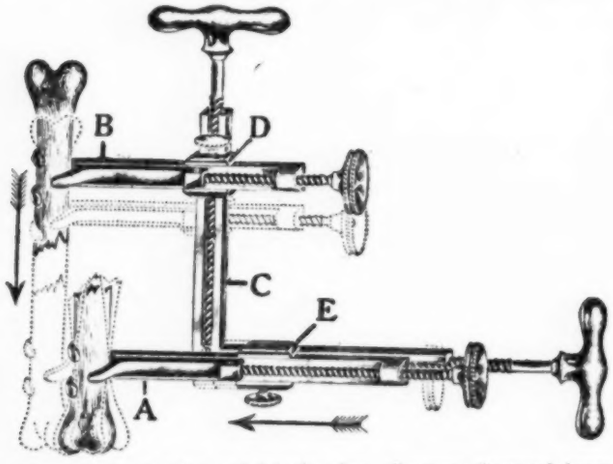
4. Wash quickly in tap water, dry and examine.

With this method, good preparations showing both the nuclear chromatin and the cytoplasm of the malarial parasite are obtained. The method is economical since very little of the methyl alcohol solution is used; and this is important in the tropics and at places far removed from the base of supplies. The slides being always in the vertical position, any precipitate which forms falls immediately to the bottom of the vessel. Soaking the slide in water during Step 2 does not affect the staining of the chromatin in the least, but does dissolve out most of the blue; this is replaced, however, in Step 3 by a better blue than any of the methyl alcohol stains are capable of giving. The whole point of the method, so far as malarial parasites are concerned, is that an intense cytoplasmic stain is added to the excellent chromatin stain obtained with Wright's, Leishman's, MacNeil's and other methyl alcohol stains, making the parasites much more distinct and more easily and quickly recognized in the routine examination of many slides for malaria.

APPARATUS FOR FRACTURED BONES

WILLIAM E. SCHROEDER, M.D., CHICAGO

The instrument consists principally of three parts—an L-shaped arm, *C*, the two branches of which carry two carriages and two bone clamps. The removable carriages, *D* and *E*, are movable in two directions, one laterally



Apparatus for holding and bringing into alignment fractured bones of the extremities, for the purpose of applying bone plates, splints of absorbable material or human bone grafts.

and the other away from or toward the operator, as may be required. Mounted on the two carriages are two strong and adjustable bone clamps which are modifications of the well-known Lowman clamp.

The illustration shows quite clearly the method employed in bringing the bone ends into apposition. The two bones are grasped by the clamps, *A* and *B*, these clamps then being attached to their respective carriages and held fast by means of heavy screws. Numerous anchoring points in the side of the clamps permit the thumb screw of holding the clamps firmly with but little exertion on the part of the operator. By means of a worm gear actuated by hand grips, each carriage with the clamp attached can be moved. Thus the bones can be brought into alignment no matter whether they override or in whatever position they may be. Immense traction can thus be had with very little effort, and once the parts are adjusted, they are held firmly together until plates, splints or grafts are applied or inserted. The instrument is made entirely of steel, and can be easily taken apart for sterilization.

25 East Washington Street.

Special Article

PRACTICAL PHARMACOLOGY *

(*Continued from page 2067*)

XXV

ANTIEMETICS—GASTRIC SEDATIVES

This heterogeneous group, if it can be called a group, of drugs will be discussed briefly. The physiology of emesis which has been discussed in the preceding pages suggests the nature of those agents which may be used to lessen nausea and vomiting, for it is obvious that if emesis results from irritation of the gastric mucous membrane and from stimulation of the vomiting center in the medulla, emollients, demulcents, and other protective agents will lessen the local gastric irritation, and if relief is urgently demanded depression of the central nervous system may be resorted to, though this is seldom necessary, except as a temporary measure, for example, when it becomes necessary to prevent vomiting while administering a drug by the stomach.

Unfortunately, we have no drug which depresses the vomiting center without causing an undesired depression of other nervous centers.

Occasionally vomiting results from reflexes arising elsewhere than in the stomach and other measures than those just mentioned must be employed, for it is well known that foul odors and other purely psychic influences may cause nausea and vomiting. Psychic influences may contribute to gastric disturbances, or may prolong them even when they are not alone sufficient to induce actual emesis, and attention should be paid to such influences.

Heat and humidity in the atmosphere interfere with digestion and contribute markedly to nausea and vomiting when there may be another exciting cause.

Vomiting occurring after ether anesthesia usually ceases spontaneously after the mucus which has been swallowed is expelled but emesis occurs frequently when food is taken some hours after chloroform anesthesia. Hot water—not tepid—should be sipped, or a glassful may be drunk if small amounts do not give relief. Cracked ice is sometimes more serviceable than hot water. Thirst following chloroform anesthesia may be relieved by drinking hot water, when it is taken easily, but as this causes diuresis, which may or may not be indicated, and since the taking of rather large quantities of water tends to tax the stomach unduly, rectal injections of warm water may be used to avoid gastric irritation, warm water being retained better than cold.

Infants regurgitate milk without indications of gastric disturbance, when more than sufficient is taken, but when vomiting with distress occurs, due to gastric disturbances, it may indicate the need of substituting barley water for the regular food for a day or two.

When vomiting is secondary to diphtheria it is said to indicate cardiac weakness demanding urgent relief for the heart.

Vomiting occurs in nephritis and disturbances of other organs in which the stomach is not irritated directly, and if the emesis is severe and persistent it

* This is the twenty-fifth of a series of articles on useful drugs — on practical pharmacology for the general practitioner. As soon as completed, these articles, elaborated by additional subjects, will be published in book form.

may call for sedatives for the vomiting center, in which case morphin may be injected subcutaneously.

Cyclic vomiting has been described as accompanying a variety of symptoms, and is probably not dependent on a single cause. Its treatment cannot be discussed here as the symptoms are too various and these call for separate treatment.

The vomiting of pregnancy often taxes the resources of the obstetrician, and occasionally it cannot be relieved by any means short of terminating the pregnancy. It would be profitless to enumerate all of the drugs which have been suggested for the relief of this symptom, for such a list would be little less than a catalogue of the materia medica. Hygienic and dietary measures appear to be the main dependence in such cases. Psychic influences play an important rôle in this condition. Cerium oxalate gained a certain degree of popularity in the relief of vomiting from this and other causes, but there is no evidence that it has any therapeutic value.

Nausea and vomiting which result from indigestion require rest for the stomach, which should be emptied by washing with a weak alkali if the vomiting does not suffice to remove mucus. A weak solution of sodium bicarbonate may serve the double purpose of dissolving the mucus and causing its removal by vomiting, when there is ineffectual retching.

When there is gastric catarrh, requiring protectives, bismuth subnitrate or subcarbonate may be used; these are preferably administered in the form of powders or mixtures and are not advantageously given in compressed tablets or even in the form of capsules. Acidity may be neutralized by lime-water, magnesia, or by a solution of sodium bicarbonate.

Depressants of the vomiting center include hydrated chloral, morphin and opium and cocain, and in fact, probably all hypnotics and general anesthetics.

EXPECTORANTS

The respiratory passages are lined with ciliated epithelium, and normally the secretions of the mucous glands are moved toward the mouth (or anterior nares) by the movement of the cilia, but when the secretions in the smaller air passages become excessive during inflammation, or when they become thick and tenacious, the cilia are incapable of effecting their removal, and coughing is induced. If the secretions become excessively viscid even coughing may be incapable of effecting their removal and it becomes necessary to liquefy them by increasing the secretion of mucus or by means of alkalies.

As previously stated, all nauseants increase the secretion of mucus, hence in practice we choose an agent which has a persistent nauseant action, with a minimum depressant effect on the central nervous system.

Antimony and potassium tartrate is absorbed very slowly from the gastro-intestinal tract, hence small doses suffice to induce prolonged nausea of slight degree, and it is commonly used in the form of a solution or the compound mixture of glycyrrhiza in the early stages of laryngitis and bronchitis when the secretion is usually scanty and the cough troublesome.

The choice of expectorants is often largely empirical; we do not know whether any of them stimulate the cilia to increased activity or not, and it has been suggested that some of them may act on the smooth muscles of the alveoli and terminal bronchioles in the lungs, increasing their peristaltic movements and forcing mucus accumulations into the bronchi, as the alveoli and the terminal bronchioles are not provided with cilia.

Many salts, including sodium chlorid, ammonium chlorid, and potassium iodid, increase the secretory activity of the mucous glands, effecting the liquefaction of the mucus through the alkalies contained in the secretions, and by diluting these with the increased fluids secreted.

It seems probable that the especial usefulness of ammonium chlorid as an expectorant may depend partly on the formation of very small amounts of ammonium carbonate in the bronchial mucous membrane, which is especially effective in liquefying tenacious mucus.

A cough which is merely sufficient to remove the secretions from the air passages does not call for treatment, but when there is considerable irritation with frequent coughing while the secretion is scanty, sedatives, such as codein, are indicated. In some cases it is desirable to increase the secretion by means of a nauseant while diminishing the irritation with a sedative to the point that the cough will just suffice for the removal of the secretion.

Patients frequently demand relief from cough when free secretion contraindicates interference.[1]

Excessive bronchial secretion may be lessened in various ways; atropin depresses the vagus endings in the glands; various volatile oils including the oils of turpentine, of cubebs, and of copaiba are sometimes used, but terpin hydrate has almost completely supplanted the volatile oils for this purpose. Balsam of Peru, benzoin, creosote and other irritants are used in this way.

Syrup of tolu and syrup of wild cherry are little more than vehicles, the hydrocyanic acid in the latter being present in the merest traces and without therapeutic effect.

The compound syrup of white pine of the National Formulary contains chloroform and morphin in addition to extracts of white pine, wild cherry, sanguinaria and other substances—a typical "shot-gun" mixture of nauseants, depressants of the respiratory center and stimulants of the bronchial mucous membrane.

Sore throat is best treated with gargles, sprays, or demulcents in the form of lozenges. A dilute solution of hydrogen peroxid is useful for cleansing the throat, or a hot 5 per cent. solution of potassium chlorate may be used as a gargle; to this may be added a few drops of solution of ferric chlorid. Small ulcers or areas of inflammation in the throat may be swabbed with cotton dipped in a mixture composed of one part of solution of ferric chlorid to ten parts of glycerin.

The official lozenges of ammonium chlorid are useful in treating sore throat but it is not easy to explain the effect of the ammonium chlorid in that case. Lozenges of elm bark allay slight irritation of the throat.

There are few conditions in which self-medication and its unfortunate consequences are more common than in coughs and "colds," and there is a striking similarity between the composition of nostrums advertised to physicians in numerous medical journals and that

1. The following incident illustrates the unfortunate results of interference in such cases. A patient suffering from a cough with free secretion received a mixture containing morphin, and expressed his satisfaction at the prompt relief afforded. Later he felt greatly discouraged because (as he supposed) he had "caught fresh cold," which he attributed to his low resistance. In fact, the morphin suppressed the cough while the secretion continued, becoming purulent, and the necessary cough returned when the effects of the morphin had passed away.

of the patent medicines, so-called, which are advertised directly to the public. It is obvious that it matters little, so far as the consequences are concerned, whether the patient doses himself with Ayer's cherry pectoral or Jayne's expectorant, or has compound syrup of cocillana or glyco-heroin (Smith) prescribed for him by a physician.

DOSAGE

The nauseant dose of several of the emetics has been given. The dose of ammonium chlorid is commonly stated as from 0.3 to 1 gm. (5 to 15 grains) but it is much more frequently used in doses of from 0.15 to 0.2 gm. (2 to 3 grains). The troches of ammonium chlorid each containing 0.1 gm. (1½ grains) with extract of glycyrrhiza, tragacanth and sugar, flavored with tolu, afford a convenient form of treatment for sore throat. It may be prescribed for cough (laryngitis or bronchitis) somewhat as follows:

	gm. or c.c.	
Ammonii chloridi	5	℥ i
Syrupi acidi citrici	50	℥ iss
Aquae, q. s. ad	100	℥ iii

M. Sig.: One teaspoonful every two or three hours.

Ammonium chlorid has a disagreeable taste which is disguised somewhat by the acidity of the mixture.

Ammonium carbonate is given in doses of 0.25 gm. (4 grains). Physicians sometimes overlook the acid character of syrup of squill and prescribe it with the strongly alkaline ammonium carbonate.

A nauseant and sedative may be prescribed together somewhat as follows:

	gm. or c.c.	
Codeinae sulphatis	0.5	gr. viii
Syrupi ipecacuanhae	30.0	℥ i
Aquae, q. s. ad	100.0	℥ iii

M. Sig.: One teaspoonful every two or three hours.

One should avoid the use of too much of the sedative in such cases, as this will lead to the total suppression of the cough. Terpin hydrate is given in doses of 0.12 gm. (2 grains) in powder, capsules or dissolved in elixir.

Many of the patent medicines, so-called, which are sold directly to the public, as well as those which are advertised directly to physicians, contain saponin derived from sanguinaria or other source, and a sedative such as heroin or morphin. No ready-made mixture is suitable for any considerable number of patients, because the doses of nauseants and sedatives should be adjusted carefully to the needs of each patient.*

ARSENIC

Toxic doses of the strongly ionizable inorganic compounds of arsenic cause gastro-enteritis with vomiting, diarrhea and abdominal pain, these symptoms being commonly delayed for half an hour or more. The first symptom frequently is a feeling of constriction in the throat with difficulty in swallowing. The evacuations are normal in appearance at first but later become watery and contain shreds of desquamated intestinal epithelium closely resembling the "rice-water" stools of Asiatic cholera. The fluid, unlike that of simple diarrhea induced by saline cathartics, consists of the serum of the blood, or it may also contain some blood, and this loss of serum results in a train of symptoms closely resembling those of actual hemorrhage. There is weakness, dizziness, headache, cold sweat and collapse. The features are pale and shrunken, the pulse weak, the respiration deep, later depressed. The symptoms are intensified until coma and death occur. Convulsions may occur (asphyxial) or they may be absent. The urine is commonly diminished or totally suppressed, because of the increased viscosity of the blood and the lowered blood pressure. Death may result from either circulatory or respiratory failure, that is, either the heart or the respiration may fail first, but when both are affected so profoundly each reacts upon the other, so that one cannot say that either alone is the cause of death.

The gastro-intestinal symptoms have been attributed to the local irritant action of arsenic, but they are now considered as the effects following absorption, and are explained in the following way: Arsenic causes paralysis of the walls of the capillaries, and later those of the arterioles, especially of the splanchnic region, rendering them more permeable than normally, so that there is a copious effusion of serum or even of blood, into the tissues. After the administration of very large doses of arsenic to animals one may observe extravasations of blood beneath large areas of the peritoneum. The escape of serous fluid raises blisters beneath the gastro-intestinal mucous membrane, and this is soon desquamated with the escape of large amounts of serum into the stomach and intestine, causing the "rice-water" diarrhea. The diarrhea and its attendant pain and loss of water cause a great fall in the blood pressure, and this is later augmented by the direct action of the arsenic on the heart, should the patient survive long enough for this action to take place.

Such serious disturbances of the circulation are always attended with corresponding depression of the central nervous system; especially is this true when the circulatory changes are induced suddenly. One has only to recall the frequency of dizziness due to interference with the cerebral circulation when one rises suddenly from a sitting or recumbent position, to appreciate that the great loss of serum in arsenic poisoning and the resulting circulatory disturbance must cause a variety of secondary effects.

If vomiting occurs early the symptoms may be of almost any degree of severity, because much, or comparatively little, of the arsenic may be evacuated thereby, dependent partly on the amount which has passed into the duodenum, or the poisoning may take on an extremely chronic character, even from a single dose.

There should be little difficulty in diagnosing chronic arsenic poisoning following the typical symptoms of acute poisoning, or where it is known that a large dose of arsenic has been taken, but the symptoms resulting from the repeated administration of very small amounts are often obscure and require patience for their recognition.

The symptoms of acute and chronic arsenic poisoning are detailed in almost all text-books of pharmacology and materia medica, and every physician should familiarize himself with these symptoms because of the frequency with which this type of poisoning occurs.

It will suffice for our purposes at present to enumerate some of the symptoms of the chronic type, merely to show the necessity for more careful study than it commonly receives. The symptoms are sometimes divided into three stages; in the first there is lassitude, loss of appetite, and there may be nausea and vomiting. This stage might lead one to suspect the presence of typhoid fever. The intestinal symptoms

* Owing to lack of space the materia medica of this group is omitted from THE JOURNAL. It will be included when this series is issued in book form.

may be present, or they may be absent. In the second stage there may be symptoms resembling those of a "cold" owing to the irritation of the mucous membranes of the larynx and nose and of the conjunctiva. Various affections of the skin are described as occurring in this stage, including a typical discoloration or blackening.

In the third stage there are disturbances of sensation and motion in the hands and feet, and peripheral neuritis, together with numerous other manifestations which require careful consideration. The symptoms are not sharply marked off in the stages mentioned, but many of those commonly described as belonging to the second or third may appear earlier than this classification would indicate.

When vague symptoms lead one to suspect even the possibility of chronic arsenic poisoning the urine should be examined for traces of the metal. Of course one would not expect to obtain evidences of the poison by the grosser tests, but, on the other hand, the most delicate tests enable one to detect the faintest traces of arsenic in the urine. Such traces have comparatively little significance unless this evidence is supported by others of great weight, because traces of arsenic may be derived from foods containing it, either as a natural or as an added ingredient.

Chronic arsenic poisoning is attended with degenerative changes in the walls of the capillaries and later in the intestinal epithelium, and in various organs, including the heart, liver and kidneys.

Icterus results from the changes in the liver, and effusions occur in various tissues, that into the eyelids being usually early and fairly characteristic. The damage to the heart may fail to attract attention in the presence of other symptoms, such as nephritis, to which the attention may be mainly directed if the true cause of the trouble is not suspected.

The toxicology of arsenic is interesting from various standpoints. It played an important rôle in the crimes of professional poisoners in earlier times, and it is still employed occasionally for purposes of murder and suicide. It lends itself, unfortunately, to the poisoning of one member of a household by another when small doses can be administered frequently, because, owing to its tastelessness and lack of odor, it does not arouse suspicion and is all too easily obtained in the form of rat poison. All arsenic preparations which might be used in this way should be colored distinctively by the addition of lamp-black or indigo which cannot be mixed with most foods without attracting attention.

Fortunately, the metal can be detected in the vomitus, urine and feces, and in the cadaver long after death, so that it is probable that few adults die of acute arsenic poisoning without the fact becoming known.

The treatment of acute arsenic poisoning requires further investigation. It was accepted for many years as an established fact that as soon as possible after a poisonous dose of arsenic had been swallowed the patient should receive a large dose of moist ferric hydroxid, or preferably, the hydroxid with magnesia, which can be prepared more conveniently and quickly, when the materials are at hand.

Serious doubt has been thrown on the value of this procedure during the past few years, and the stomach should be washed out as promptly as possible whether the iron antidote be employed or not. Active catharsis should be induced with magnesium sulphate solution in order to remove any of the poison that has passed into the duodenum. Since prompt purgation is necessary in such cases, a large dose of the dilute solution of magnesium sulphate should be administered — preferably a pint of solution containing about an ounce of the salt. Naturally, purgatives are contraindicated after the intestinal symptoms have developed.

The elimination of arsenic depends somewhat on the way in which it is administered. When a toxic dose has been taken by the mouth the larger part may be evacuated with the vomitus, or with the washings of the stomach, and a large part of the remainder may be evacuated in the feces, especially if prompt purgation is induced. After absorption into the circulation arsenic may be found in almost all the body tissues. Elimination goes on very slowly indeed, so that months may elapse before it ceases to appear in the secretions, and some of it appears to be retained almost indefinitely.

A larger portion of the poison is said to be eliminated by the intestine after its oral administration, and a smaller part of the urine, but after the subcutaneous injection the kidneys eliminate more than the gastrointestinal tract. Diuretics should be administered after the subcutaneous injection of a poisonous dose if the patient is seen early, but caffein and theobromin will have little or no effect after the appearance of the "rice-water" stools because of circulatory disturbances previously mentioned; hence it would seem probable that the intravenous injection of a 2 per cent. solution of sodium sulphate, as mentioned in connection with strychnin poisoning, might be of benefit, but we are unaware of any experiments bearing on the subject.

The extraordinarily slow elimination of arsenic and its consequent tendency to accumulate in the body and to produce chronic poisoning are of especial interest in connection with the uses of arsenic in fabrics, and food preservatives.

A manufacturer of a food product used anilin to color it, the finished food as eaten containing about one part of arsenic in 20,000 million parts of food. He was probably unaware of the presence of arsenic in the anilin, and it would require about 1,000 tons of the food to furnish an amount of arsenic equal to a toxic dose for a man; nevertheless it was maintained that the practice was unlawful, though it could hardly be held that enough arsenic could be taken in that way to produce any perceptible effect in a life time, especially, as arsenic is frequently taken over long periods for its medicinal effect. Quite a different case was that of a manufacturer whose candy was found to contain six parts of arsenic per million. One pound of the candy contained as much as an average dose of arsenic for an adult, and its continued use in large amounts might very well cause symptoms.

In seeming contradiction to the preceding statement is the well-known fact that the administration of small and increasing doses of arsenic by the mouth leads to a higher degree of tolerance, apparently through an acquired resistance to absorption from the gastrointestinal tract, for such tolerant animals are not more resistant than others to arsenic administered subcutaneously. Remarkable stories of tolerance are commonly told of the arsenic eaters of the Tyrol.

As little as 0.1 gm. (1½ grains) of arsenic has proved fatal, but very much larger oral doses have been survived, and if vomiting occurs within less than half an hour after a fairly large dose has been swallowed the chances of recovery are fairly good, but of

course one cannot depend on this alone, and other treatment should be instituted, as previously stated. There is an unfortunately widespread belief among the laity that larger doses of arsenic may be safer than smaller, but toxic ones. This is doubtless based on the fact that large doses do occasionally induce emesis in time to save life, while smaller doses may prove fatal.

In view of what has been said of the widespread use of arsenic in the arts, in medicine and in foods, with the consequent frequency with which at least small amounts may be taken without the knowledge of the patient, and the extreme slowness with which elimination takes place, it is obvious that the detection of traces of arsenic in the excreta or in a cadaver does not prove that observed symptoms or death resulted from arsenic in a given case, and one will understand the necessity of a careful study of the actions of arsenic before expressing opinions that may be of far-reaching importance.

The administration of small amounts of arsenic to young animals may cause them to grow more rapidly than other members of the same litter that receive the same food without the arsenic. Several observers found that the bones of the animals that received arsenic were longer and thicker than those of the controls; that their fur was glossier and other evidences of rapid development were also observed, but these effects are not always obtained and other investigators came to different conclusions with regard to the effects of arsenic on metabolism. Poisonous doses cause fatty degeneration in various organs, and other disturbances of metabolism.

Various explanations have been offered to account for the more rapid growth observed as the result of the use of arsenic, but it seems possible that the actions on the capillaries and the effects on the general circulation together with the stimulation of production of red blood corpuscles or of hemoglobin are concerned in the effects on metabolism.

It also seems possible that arsenic may serve to correct some adverse conditions entailed in those feeding experiments in which the greater growth was observed, for it does not seem probable that arsenic would influence growth favorably if the animals were kept under the best conditions of living and exercising in the open air. At least, no one would think of advising the routine administration of arsenic to healthy little children living under hygienic conditions.

Certain of the organic compounds of arsenic which ionize but little are much less active than the inorganic compounds that have been discussed. Cacodylic acid, which differs from arsenic acid by having two methyl groups in place of two hydroxyls of the latter, has long been known, the sodium salt having been introduced about fifty years ago. Sodium arsanilate was introduced into therapeutics in 1902 under the name of atoxyl under the mistaken impression that it was nontoxic. It exerts the arsenic action, though less violently than arsenic trioxid in equal weights, and in addition it is prone to cause blindness through atrophy of the optic nerve. When atoxyl was submitted to the Council on Pharmacy and Chemistry its composition was investigated, and it was shown that the arsenic is not present in the trivalent state as had been supposed, but in the pentavalent.

Following the introduction of organic compounds of arsenic, Ehrlich investigated a large number with the object of finding one capable of exerting the well-known trypanocidal action of the metal without the toxic action on the host, or at least of finding a compound in which the relative toxicity for the parasite and the host would permit of the administration of a single dose that would at once destroy all the micro-organisms in the blood.

As a result of this search Ehrlich and his co-workers brought out salvarsan, or arseno-benzol, more correctly called arsen-phenol-amine hydrochlorid. It has also been named "606" in reference to the laboratory number given the compound.

From the results of the early studies it was announced that a single dose of salvarsan was capable of destroying all of the micro-organisms of syphilis in the human body in suitable cases. It was also highly extolled in the treatment of various other diseases, including relapsing fever, and at the same time it was said to be relatively harmless to man in the dosage advised.

The literature relating to salvarsan is already enormous, and while it is not feasible to review this even partially, it may be said that a single dose apparently effects a complete cure only when it is given shortly after infection, if at all, and that it is far from being harmless, numerous deaths being undoubtedly attributable to its use even with the most careful technic.

Unfortunately, the spirochetes of syphilis may become more resistant than normal to arsenic after repeated doses, and it is usually necessary to combine the use of arsenic with that of mercury.

Neosalvarsan is a soluble compound of salvarsan thought by some to be tolerated better than the original product.

THERAPEUTIC USES

Arsenic trioxid is applied to ulcerated surfaces as an irritant, but its use is attended with severe pain. It has long been used in domestic practice and occasionally by physicians as a caustic for the removal of malignant growths, in the form of pastes. The action cannot be controlled accurately, it is very painful and there is some danger of the absorption of a poisonous dose when it is applied in this way. Its use is not recommended. It has long been employed and is still used as an application to ulcerated surfaces and by dentists for destroying the nerves in carious teeth.

It is used internally in a variety of disorders in which its mode of action cannot be explained satisfactorily. For example, it is used in neuralgia of a periodic character, and in chorea, in which it is of doubtful value. It is used in anemia, in which it probably stimulates the organs involved (bone marrow) to a more rapid regeneration of the red blood corpuscles or the hemoglobin. It is also used in pernicious anemia, in leukemia and in Hodgkin's disease (malignant lymphoma, or hypertrophic disease of the lymphatic glands of the body, attended with anemia). In these diseases its temporary effects are often markedly beneficial, but relapses almost invariably occur.

It is often used to improve the nutrition when the disturbance results from obscure causes, but, of course, it is not suited for use in all of those cases.

It has been recommended for use in diabetes, but like other drugs, it usually fails in that condition.

Arsenic is said to be useful in various skin diseases, such as psoriasis, lichen planus, chronic eczema, pemphigus, dermatitis herpetiformis, chronic urticaria and disturbances involving the sweat glands. It must

be remembered, however, that the treatment of skin diseases by the general practitioner involves many difficulties because of the obscurity of the etiology in these conditions, hence they should be treated by dermatologists when they present unusual difficulties or conditions with which the practitioner is unfamiliar.

Attention has been called to the fact that the fur of animals used in experiments with arsenic was glossier than that of the controls, and horse dealers have long utilized this action of arsenic in improving the coats of horses. These results suggest the use of arsenic in man when there is faulty nutrition of the skin.

Acute inflammation of the skin contraindicates the use of arsenic.

The organic compounds of arsenic have a distinct field of usefulness in various diseases of protozoal origin, including sleeping sickness (trypanosomiasis), malaria, relapsing fever and syphilis, but the side actions, especially that on the optic nerve (with atoxyl), have greatly interfered with its use.

Arsenic has long been used in malaria, especially in the chronic forms which have resisted quinin, arsenic and quinin being commonly used together in those cases.

The cacodylate attained to some degree of importance many years ago when it was found that it exerts the actions of arsenic over a longer period than the inorganic forms and that it is less toxic.

Sodium arsanilate was used extensively for a time in the treatment of sleeping sickness but numerous cases of blindness resulted, and it has fallen into disuse for that purpose.

Salvarsan is widely used in the treatment of syphilis; it is given alone soon after infection or in combination with mercury in the later stages. It is also employed in the treatment of relapsing fever and in many other conditions, sometimes with good results, sometimes with harmful effects.

The results reported soon after the introduction of salvarsan raised hopes which subsequent experience proved were far too optimistic, but when the early literature has been discounted sufficiently we still have in it a valuable remedy.

Headache, nausea and malaise commonly follow the intravenous injection of salvarsan, the symptoms lasting for from twelve to twenty-four hours. Aside from these after-effects certain nervous effects have been observed. These symptoms — termed nervous relapse — are believed to be due to an increased activity of the spirochetes and they call for another dose of salvarsan or treatment with mercury.

Arsenic is sometimes used in the most diverse conditions including asthma, tuberculosis, bronchitis, leukemia, splenic anemia, and in numerous other diseases, and one is led to suspect that when improvement follows its use in those conditions it is merely a coincidence or that this improvement is attributable to the effects of arsenic on metabolism in general rather than to any direct effect on the diseased organs or the causes of the disease.

All forms of arsenic should be used cautiously or not at all in the presence of disease of the eye, especially of the retina, even if it be of syphilitic origin, because of its tendency to induce optic neuritis and blindness, but salvarsan is said to cause optic neuritis in few instances. Arsenic is contraindicated in severe cardiac and renal disease, and salvarsan cautiously used in syphilitic infants because of the danger from liberated endotoxins when the spirochetes are destroyed.

DOSAGE

For ordinary affections of metabolism or for a tonic influence arsenic trioxid is given in doses of from 0.001 to 0.002 gm. (1/60 to 1/30 grain). In diseases of the blood the dosage should be regulated according to the effect, but it is well to use as large doses as the patient will tolerate.

The various forms of inorganic arsenic are frequently administered in increasing doses until symptoms of mild intoxication appear. One may begin with 0.003 gm. (1/20 grain) of arsenic trioxid, three times a day, and increase by 0.001 gm. (1/60 grain) three times a day.

Solution of potassium arsenite and solution of arsenous acid may be given in doses of 0.2 c.c. (3 minims) three times a day, and increased by 0.05 c.c. (1 minim) three times a day. A slight toxic effect is indicated by nausea, colicky pains or a puffiness under the eyes. The presence of albumin in the urine may also be observed. Such symptoms may make it advisable to discontinue the administration of the drug for a time.

Solution of arsenous and mercuric iodids is usually administered in doses of 0.1 c.c. (1½ minims).

Sodium arsenate is given in doses of 0.003 to 0.005 gm. (1/20 to 1/10 grain) three times a day and increased as with other preparations of arsenic.

Of the organic combinations of arsenic, sodium arsanilate, (atoxyl, soamin), is given in doses of 0.02 gm. (1/3 grain) gradually increased, and sodium cacodylate may be given in doses of 0.03 gm. (½ grain). The former of these two products is used only by injection; the latter is frequently administered hypodermically though it may also be administered by mouth.

The dose of salvarsan is 0.5 gm. (7½ grains). Since it is not suited for oral administration it must be given intravenously, subcutaneously or intramuscularly, but intramuscular injections have been followed in several instances by the toxic effects of arsenic; furthermore, the intramuscular injection is painful and is usually followed by a painful inflammatory nodule which persists for some time. It is seldom employed by those who have mastered the technic of the intravenous injection and no one should undertake to administer salvarsan intravenously without having mastered the somewhat difficult technic.

Salvarsan, being acid, is neutralized and suspended in a neutral fluid for subcutaneous or intramuscular injection. A clear solution in sterile alkaline fluid is used for intravenous injection.

The powder decomposes rapidly on exposure to the air, and suspensions and fluids intended for injection should be used at once. If any part of the contents of a tube remains unused when a dose is administered it should under no circumstances be mixed with a subsequent dose but should be thrown away. Even those tubes that are cracked before being used, permitting the action of the air, should be rejected. The water used for making intravenous injections should be distilled shortly before being used. Various forms of apparatus are advised by different authorities, but most of the apparatus employed for the injection can be had in any first class pharmacy or instrument maker's shop.*

(*To be continued*)

* Owing to lack of space the materia medica of this group is omitted from THE JOURNAL. It will be included when this series is issued in book form.

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SATURDAY, JUNE 26, 1915

On account of the large amount of space occupied by the Index in this issue of The Journal, certain departments have been omitted entirely and others abbreviated. The distance from The Journal office of the place of the annual session, together with the fact that this is the last number of the current volume, makes it desirable to omit the publication in this issue of any of the minutes. An effort will be made, however, to present in the next issue — July 3 — a complete report of the proceedings of the session.

THE INDEX

This issue of The Journal contains the index to the current, or sixty-fourth volume of The Journal, including the current medical literature which has been listed from week to week. Original articles in the leading medical journals of the United States and the principal foreign countries are included under the latter head.

In the author index appear the names of all who have contributed articles to The Journal or to any other journal listed in the current literature department, and the names of those whose papers are abstracted in the medical society reports in The Journal. In the subject index are complete references to all reading matter in The Journal, and references to original articles in all the domestic and foreign journals listed. To facilitate the use of the Index, not only are titles arranged under the subject of the article with double entry when necessary, but also there are numerous cross-references. The figures in boldface type refer to reading matter in The Journal.

The Index appears in pamphlet form[1] under the title "Guide to Current Medical Literature." This pamphlet contains, in addition to the author and subject indexes published in this issue of The Journal, the titles of the articles listed, arranged chronologically and by journals, as in the Current Medical Literature department. It is issued in separate form for convenience — to make it unnecessary to handle the bound volume of The Journal.

Just preceding the Index is a list of the journals indexed during the past six months. Any foreign journal, except those preceded by a star, will be lent by The Journal to subscribers and Fellows of the American Medical Association in the United States, with the understanding that such journal will not be retained by the borrower over three days. Requests for journals should be addressed to the Library of the American Medical Association, and six cents in stamps should be enclosed to cover the average expense of mailing. No domestic journal will be lent, as these can be obtained direct from the publishers as easily and as quickly as from The Journal. The addresses of the domestic journals are given.

It will be noted that in the Index in this number of The Journal there is a marked increase in the number of headings devoted to war subjects. The words "soldiers," "war," "army," "wounded," "wounds," "typhus," "tetanus," etc., are followed by numerous references occupying from three to ten times the amount of space devoted to them in previous indexes.

1. The Guide to Current Medical Literature may be obtained from the Association office at 50 cents a copy.

FOURTH OF JULY ANTICIPATIONS

The conflagration in Europe modifies all American events, and it will be of interest to observe its effect on our annual mimic warfare of July 4. Will the general depression of spirits and resources reduce the amount of explosive exuberance, or will the increased familiarity with gunpowder and bloodshed increase our notorious contempt of human life and suffering? The Journal has collected statistics on the injuries of the Fourth for twelve years, and the curve is now well enough established to indicate very clearly the annual extent of the old-fashioned celebration. Last year, for some unexplained reason, there was a slight increase in the total number of accidents and deaths, there being 1,506 accidents and forty deaths in 1914 as against 1,163 accidents and thirty-two deaths in 1913. Of the accidents last year, Pennsylvania with 487 and New York with 250 accounted for nearly half the total Independence Day devastation of the country, and it is in these two states especially that improvement must be made. Since The Journal first began to compile these statistics, Pennsylvania has always led in the number of accidents, usually by a wide margin. It has been suggested, perhaps facetiously, that this is the outcome of the possession of the Liberty Bell and the traditions of the Cradle of Liberty; if so, there is naturally a doubt whether the possession is worth the price. It has been certainly demonstrated that a community which wishes to free itself from this sort of destruction of person and property can do so. Not a few large cities have found it possible to pass through the Fourth without a single accident. It fol-

lows, then, that the number of Fourth of July accidents is the measure of the effort made by a community to rid itself of this long-suffered nuisance.

This year one factor may make for an increased number of accidents — the occurrence of the Fourth on Sunday, which results in two days of celebration in many communities. We must, therefore, be prepared to do our part in reducing the number of fatalities from these accidents. The reduction in the total number of deaths from tetanus to three in 1914, as compared with 150 cases in 1909 and 417 in 1903, is far out of proportion to the reduction in the number of accidents from which tetanus might have resulted. This indicates that the medical profession has learned how to prevent this most frightful sequel of injuries, and is fully alert to the dangers that reside in Fourth of July wounds. The European war has demonstrated on a hideously large scale the frequency of tetanus in unclean wounds and the great value of tetanus antitoxin in prevention, especially when its use supplements adequate surgical cleansing of the wounds. The importance of this point need not be dilated on, as was necessary twelve years ago, when neither the danger of tetanus nor the efficacy of antitoxin as a prophylactic was generally recognized. The same may be said of the intraspinal injection of tetanus antitoxin in developed cases of tetanus. This is now a recognized procedure which unquestionably gives results far superior to those obtained by any other method of treatment. At the recent meeting of the Association of American Physicians in Washington, Nicoll reported that of twenty patients treated in the New York City Department of Health by intraspinal injection of antitoxin, there had been but four deaths.[1] Improved results have also been reported from the military hospitals of Europe from the intraspinal administration of tetanus antitoxin.

It may be well also to repeat the instructions outlined a year ago,[2] for the prophylaxis of tetanus in Fourth of July injuries:

1. Carefully and thoroughly remove every particle of foreign matter from the wound, laying it open; an anesthetic should be given if necessary.

2. Dry the wound thoroughly, and paint it and the surrounding parts as carefully as possible with iodin, or else cauterize it thoroughly with a 25 per cent. solution of phenol (carbolic acid) in glycerin or alcohol.

3. Apply a loose wet pack, using a solution of some such antiseptic substance as boric acid or alcohol.

4. As soon as possible inject intravenously or subcutaneously 1,500 units of antitetanic serum and continue the injections if indications of possible tetanus arise.

5. In no case close the wound. Allow it to heal by granulation. Remove the dressings and packing each day and apply fresh ones.

1. Nicoll, Matthias: Intraspinal Administration of Antitoxin in Tetanus, THE JOURNAL A. M. A., June 12, 1915, p. 1982.

2. The Prophylaxis of Tetanus, Current Comment, THE JOURNAL A. M. A., June 20, 1914, p. 1971.

VACCINE THERAPY IN TYPHOID FEVER

It is difficult to arrive at a just estimate of the value of vaccines in the treatment of typhoid fever, because the evidence for and against their use is derived from two widely different sources. From a theoretical standpoint, such a procedure has little justification. It is well known that there is an extensive invasion of the blood by the infecting organism early in the course of the disease, and it seems reasonable to assume that these invading organisms furnish sufficient antigenic stimulus to cause the maximum antibody formation. On the other hand, if this antibody formation is delayed early in the course of the infection, vaccines may be of value in stimulating such a response. In the field of clinical medicine, many observers have reported striking results from the use of vaccines, and it is the common opinion of these clinicians that they are efficacious in the treatment of typhoid fever.

The clinical data in the literature pertaining to this phase of the treatment of typhoid fever have recently been reviewed by Krumbhaar and Richardson[1] of Philadelphia. This analysis includes more than 1,800 cases, and in 95 per cent. of these, favorable results were observed. Thirty-five of the thirty-nine observers concluded that the vaccine was useful as a therapeutic measure. In almost all instances, the course of the infection was favorably influenced, and in many series the mortality was reduced. In a series treated by Petrowitch, the mortality was 3.2 per cent., as compared with 8 per cent. in 220 unvaccinated patients. Krumbhaar and Richardson used vaccines in the treatment of ninety-three typhoid patients in the Pennsylvania Hospital during the past three years. Their results were so promising that they consider the use of vaccines an important procedure in the routine treatment of the disease. The symptoms were rarely altered beyond a transitory rise in temperature; but relapses and complications were diminished in frequency, and when vaccine treatment was instituted early in the course, there seemed to be a favorable influence exerted on the intensity of the infection. Since agglutination is often absent during the first two weeks of the attack, these investigators assume that antibody formation is often delayed, and that by the use of vaccines an early activity of this process can be brought about. The experiments of Gay and Claypole also suggest that there may be a hyperleukocytosis following the injection of a vaccine during the course of typhoid fever. Should these experiments receive confirmation, a good theoretical basis would be afforded for vaccine therapy in typhoid.

The type and dosage of the vaccine have had no apparent influence on the results obtained. Sensitized vaccines have been strongly advocated by Besredka,

1. Krumbhaar, E. B., and Richardson, R.: Am. Jour. Med. Sc., 1915, cxlix, 406.

Metchnikoff, Garbat and others, and on theoretical grounds such vaccines would be favored; but the majority of investigators have had good results with suspensions of dead bacteria prepared according to Wright's method. Although autogenous vaccines generally have been preferred, stock vaccines prepared from organisms selected for their high agglutinogenic power have been efficacious in the hands of many. Reports, however, have been so uniformly favorable with all preparations, that it seems as if the type used is of secondary importance. The dosage has also varied widely with different investigators. Semple, Waters, Petrowitch and others used small doses, while Foster, McArthur, Fletcher and Meakins obtained equally good results with large doses. Krumbhaar and Richardson gave 500 million as an initial dose and two or three larger doses at short intervals. They conclude that their results were more favorable in the cases in which large doses were given. The dosage, however, must be gaged by the general condition of the patient. When the patient is very toxic, only small amounts of vaccine can be used with any degree of safety. Previous mention has been made of the remarkable results obtained by Ichikawa from the intravenous injection of sensitized vaccines.[2] Using this method of inoculation, he was able to produce a rapid drop in the temperature to normal and often an early recovery. In his cases, mild intestinal hemorrhages occurred in a few instances following the injections; but these hemorrhages were no more numerous than in the unvaccinated patients. Subsequent investigators[3] also report favorable results from the intravenous method of administration of the vaccine, but they strongly emphasize the danger of a severe general reaction in some instances. Signs of collapse, severe diarrhea and intestinal hemorrhages are complications which have occurred simultaneously with the rapid fall in temperature, and in a few instances there was an unfavorable termination. The ultimate value of this method of administration of vaccines, therefore, is a question which further observations must determine.

Including the recent encouraging reports of Goldscheider and Aust,[4] Rhein[5] and others, the clinical evidence now at hand is derived from careful observations on about 3,000 cases of typhoid fever treated with vaccines. In almost all instances, it seems that some degree of favorable influence could be noticed from their use. The observations of Elmer[6] indicate that vaccines will not prevent the attack, once infection has begun; but it seems probable that their use early in the course of the disease modifies the duration and intensity of the attack. Furthermore, in complications, especially localized typhoid infections such as periostitis and cholecystitis, and in the treatment of typhoid carriers, vaccines are of limited value. In local infections in which there is a secondary invading organism, as in pneumonia and otitis media, typhoid vaccines are probably contraindicated.

Careful bacteriologic and serologic study is an essential prerequisite to vaccine therapy, which requires an exact etiologic and early diagnosis. Before the question of the efficacy of this form of treatment can be settled fully, the mechanism of the action of vaccines in generalized infections needs to be better understood; obviously, this is a problem in the field of experimental medicine. In the meantime, the results at hand, which indicate that, used with discretion, vaccines not only do no harm, but also may be of benefit, should stimulate to further and careful observations.

2. Present Status of the Vaccine Treatment of Typhoid Fever, Current Comment, The Journal A. M. A., Feb. 6, 1915, p. 518.

3. Biedl: Wien. klin. Wchnschr., 1915, xxviii, 125. Paltauf: Wien. klin. Wchnschr., 1915, xxviii, 125. Sladek and St. Kotlowski: Wien. klin. Wchnschr., 1915, xxviii, 389. Reibmayr: München. med. Wchnschr., 1915, lxii, 610.

4. Goldscheider and Aust: Deutsch. med. Wchnschr., 1915, xli, 361.

5. Rhein, M.: München. med. Wchnschr., 1915, lxii, 427.

6. Elmer, W. P.: Study of a Recent Typhoid Epidemic, with Especial Reference to the Use of Antityphoid Vaccines, The Journal A. M. A., April 3, 1915, p. 1147.

THE URINARY PROTEIN OF NEPHRITIS

It is conceivable theoretically that the protein present in albuminous urine is derived from the kidney or from the blood through damage to the capillary wall, or is a specific protein distinct from that derived from either the renal tissue or the blood. According to Fischer's widely discussed views, the urinary protein is derived, in part at least, from the renal cells, from which it has been dissolved under the influence of acids.[1] In connection with a current belief that the urinary protein found in nephritis represents serum protein rather than tissue protein, we referred some time ago[2] to the experiments of Salus,[3] who attempted to solve the question by the use of modern serologic or biologic immunity reactions. The technic in this field has become so refined that different proteins from the same animal may possibly be distinguished, and it therefore seemed likely that the controverted questions of the origin of the proteins of nephritic urine could be reached in the same way. Salus prepared a so-called organ plasma, a solution of tissue proteins obtained after completely removing the blood from various organs by Pohl's method. He found that such an antigen is entirely distinct from the antigens of the blood. More specifically, Salus took up the question of the origin of the protein in nephritic urine, and summarizes his results as follows:[4] Antiserum for human kidney contained neither precipitins nor complement-binding antibodies for either human serum or nephritic urine; hence the latter does not contain

1. Fischer, M. H.: Oedema and Nephritis, John Wiley & Sons, New York, 1914.

2. A Controverted Theory of Nephritis, Current Comment, The Journal A. M. A., June 20, 1914, p. 1971.

3. Salus, G.: Biologische Versuche mit Organplasma, Biochem. Ztschr., 1914, lx, 1.

4. We quote from a review by Cameron, A. L., and Wells, H. G.: The Origin of the Proteins of Nephritic Urine, Arch. Int. Med., May, 1915, p. 750.

the antigens characteristic of kidney tissue. Guinea-pigs sensitized with nephritic urine or blood serum did not give anaphylaxis reactions with kidney plasma, and animals sensitized with this plasma were reactive to serum or urine only when the plasma gave distinct reactions for blood. He therefore concludes that the protein of nephritic urine must be serum protein, and not renal tissue protein.

As these biologic reactions seem to offer the greatest promise of success in determining the identity of individual proteins, THE JOURNAL stated editorially that they place the burden of proof on those who maintain that the urinary protein of nephritis is merely the dissolved contribution of kidney cells subjected to an abnormal environment, rather than escaped blood components.

In criticism of these comments, Fischer[5] remarks that Salus concluded correctly from his experiments that the protein in the urines examined by him contained blood proteins. Fischer adds that no one has ever disputed this fact, for hemorrhage through gross rupture of the blood vessels and by diapedesis is common in all types of nephritis. With reference to the failure to obtain reactions indicative of dissolved kidney protein in the urine, Fischer remarks:

> In the face of the fact that it is difficult to prepare a specific antiserum even when kidney substance is used directly, such findings are hardly conclusive. The colloid chemists, moreover, know how alterable in consequence of mere laboratory handling are the reactions of proteins, and so some argument will be necessary to make those of solid organs and of organ extracts synonymous in their minds. Salus himself recognizes these difficulties.

A much more trenchant critique, pointing out the meager and variable character of Salus' fundamental experiments, has been published recently by Cameron and Wells.[6] They are quite unwilling to admit the conclusions of Salus on the basis of what they regard as inadequate proof. In a new attempt to secure further evidence on the disputed points relating to the origin of the urinary protein, these Chicago investigators note that part of the contradiction presumably depends on the difficulties inherent in the available methods for distinguishing, even by the biologic reactions, between different proteins coming from the same animal. A series of experiments by the anaphylaxis method gave no evidence of the existence of antigens in either urine or kidney distinct from each other or from the antigens of human serum. This result, as Cameron and Wells remind us, does not answer the question of the origin of urinary protein, but merely indicates the inadequacy of the anaphylaxis method for the solution of the problem. In fairness, therefore, the questions involved therein must frankly be regarded as still open for review.

5. Fischer, M. H.: Oedema and Nephritis, 1914, p. 446.
6. Cameron, A. L., and Wells, H. G.: The Origin of the Proteins of Nephritic Urine, Arch. Int. Med., May, 1915, p. 746.

DISEASE RESISTANCE IN PLANTS

In matters of health and disease, all living things have intimate relations. The factors that increase resistance to disease in plants can scarcely fail to interest physicians. Probably at least suggestive if not directly valuable hints for the prevention or inhibition of the contagious infections in human beings can be derived from a knowledge of the natural processes by which plant resistive vitality is encouraged. There is, too, a definite assurance that certain serious human diseases—tetanus and the gas-producing bacillary infections—are caused by micro-organisms fostered by plant life, and more than a suspicion that further study may reveal other similar relations.

Dr. Otto Appel[1] has considered the analogies between plant and human diseases, and the problem of resistance. The question of alternation of hosts for certain diseases is a plant as well as a human pathologic feature. The tapeworms and echinococci require an intermediate animal host, and prevention is much easier when the relations between the hosts of the two stages can be regulated. When rust appears in a pear orchard, the danger may be removed by eliminating all juniper trees from the neighborhood, the juniper being the host for the alternate stage of the fungus. The same measure must be adopted to assure prevention in the case of red rust of wheat in countries in which the fungus does not reinfect the wheat directly, but grows in the spring on the barberry. This serious scourge has practically disappeared from Germany since the removal of all barberry and mahonia bushes from districts in which wheat is grown.

Dr. Appel declares, in words familiar to physicians of human maladies, that it is more difficult to cure a plant already diseased than to prevent the disease. Only in rare cases is the method of "cure" known. Plants are not organized like animals, and in most cases it is impossible to influence a central system. Even with that possibility, physicians find "cures" difficult enough. Some of the adjuvants in the treatment of disease in plants are suggestive of phases of our medical problems. The cure of fungous diseases of different trees by giving the roots an abundant water supply is an example of treatment based on the principle that "many fungi are unable to grow in tissues which show a high water pressure. In dry soils the water content is kept on a low basis, and this favors the attacks of the fungus." Observant physicians have found this principle, so useful in limiting plant disease, of great value in the treatment of affections due to the growth of low plant life in the human intestines. A dry diet often seems to favor putrefactive processes, while the free taking of fluids not only affects constipation favorably in a mechanical way, but also lessens the growth of disturbing micro-organisms in the intestines.

1. Appel, Otto: Disease Resistance in Plants, Science, May 28, 1915.

More important still is the securing of varieties of disease-resistant plants. The method has long been understood, but the application of the principle is only now being successfully applied. The plant specialists, however, are much farther advanced in the solution of their problems than are the eugenic specialists. Of the different species of wheats, the difference in resistance to various serious affections is very marked. As a rule the Western European varieties are resistant, while many of the Eastern varieties are liable to rust. In both regions, however, there are marked exceptions, and the plant found in Palestine some years ago, which has sometimes been regarded as the ancestor of our common cultivated wheat is, curiously enough, a non-resistant species, showing by its survival that individual vitality may surmount dangers that would seem inevitably to doom a plant variety. The subjection to certain diseases of the plants of a region hitherto spared the special contagion is sometimes followed by serious devastation among crops. The corresponding incident in human beings was well illustrated by the ravages of smallpox, of tuberculosis and even of measles among the American Indians when these diseases were first introduced on this continent by the Europeans. Nature has gradually selected the disease-resisting varieties among human beings, so that a certain immunity has developed among peoples long subjected to the contagion of particular diseases.

From a chemical standpoint, the facts concerning plants are suggestive to the student of human disease and immunity. Dr. Appel says:

> A glance at sugars and acids shows that these substances also exert an influence in disease resistance. The presence of benzoic acid in *Vaccinium vitis idaea* is supposed to be the cause of its resistance to fungous diseases. In the same way the tannins have a relation to resistance. This was shown by Behrens in his work on fruit decay, and confirmed by Cook and Taubenhaus. On the other hand, sugar favors the growth of fungi, as is shown clearly in the case of apples and pears. Henneberg even claims immunity for some varieties of potato from certain diseases on account of their high sugar content, but this has not been established beyond doubt.
>
> Finally, the enzymes exert a definite influence on immunity, the oxydases taking the lead. These ferments work directly or indirectly by producing resistant chemical substances.

Everywhere in nature, similar forces are at work, and the same problems must be solved. The outlook for a solution of the involved questions of disease resistance and immunity is more promising when it is seen that many scientific investigators are working from different sides. The most important development of modern biology came when the great principle of the existence of cells was transferred from botany to zoology by Theodor Schwann at the beginning of the nineteenth century. When Virchow took the further step of applying the cell doctrine to pathology, he made perhaps the greatest advance in modern medicine. He used to declare in later life that when these two far-reaching developments were made by himself and Schwann, the rising generation of scientific investigators in Germany were quite as much interested in botanic problems as in microscopic anatomy. It was this breadth of interest, he declared, that gave them the larger outlook which enabled them to look beyond the bounds of what had been hitherto known to newer phases of knowledge.

SOME FACTS ABOUT INSENSIBLE PERSPIRATION

However varied and important the physiologic activities of the skin may be, they usually receive scant consideration in treatises on the functions of the body or in so-called systems of medicine. This is unfortunate for many reasons, and particularly because it tends to inculcate a sort of disregard for certain properties and performances which are peculiar to the cutaneous surfaces and not without significance in medical practice. The sensory nervous mechanism involved in the covering of the body plays a highly important rôle by rendering us appreciative of our environment and responsive to a variety of influences that are wont to react on us. Much of our life of sensation is bound up with the structure of the skin, and many of our reflexes are initiated in relation to it.

These are only a few incidents in the functions of the skin. Its participation in the regulation of temperature all too often lacks appreciation, if one may judge by many misguided practices which are current in connection with the hygiene of clothing and ventilation. Although the sweat glands were discovered by Malpighi[1] as early as 1687, it required a rediscovery[2] of them in man in 1834 to direct attention to the functional possibilities which the secretion of water on the external surfaces of the body actually presents. Even then for some time doubt remained as to whether the glands are concerned with a specific output of water rather than with such activities as the sebaceous glands are now known to represent.

Ever since the days of Sanctorius (1614) the expression "perspiratio insensibilis" has been in use. For him it represented essentially the loss of body weight which could not be accounted for by the visible and weighable excreta. In part this loss obviously is due to a removal of water through pulmonary respiration, together with the excess of exhaled carbon dioxid over absorbed oxygen. There remains for consideration the losses through the skin, some of which become apparent in the form of sweat.

Can water be lost through the skin in any way other than by the mechanism of the sudoriferous glands? Is there a true insensible perspiration represented by a purely physical transport of water through the skin

1. Malpighi: De externo tactus organo, in his Opera omnia, 1687, pp. 203, 208.
2. Brechet and Roussel de Vauzeme: Ann. d. sc. nat., 1834, ii.

into the surrounding medium? Of course it has long been recognized that even where no visible drops of sweat collect on the cutaneous surfaces, water may be, and usually is being, vaporized from them. It is quite conceivable, however, that in such cases evaporation may keep pace with sweat production and thus give an impression of insensible perspiration without the intermediation of the cutaneous glands.

The longstanding uncertainty respecting the origin of water imperceptibly eliminated from the skin was dispelled by a series of observations on human individuals in whom an unusual anomaly of this organ exists. Loewy and Wechselmann[3] have had the exceptional opportunity of studying subjects in whom a defective development has resulted in complete absence of skin glands, so that both sweat and sebaceous secretion were lacking. Here, then, it became possible to investigate the occurrence of loss of water from the skin independently of sweat formation. It was found that such sweat-free persons may experience considerable output of water through the skin. The variations of such a process of elimination are considerable. The quantity may reach 600 grams of water per day for the entire body. This represents a true insensible perspiration — a diffusion of water vapor — following definite physical laws.

The observations made in these unique cases representing, it may be noted, persons having ties of blood relationship and thus exhibiting a hereditary factor in their common skin defect, supplement the facts learned from normal individuals. As a result of the different investigations,[4] it is concluded that the physical loss of water varies greatly in different parts of the body — a fact only recently verified by Galeotti and Macri[5] at the University of Naples. They found the insensible perspiration to be greatest from the surfaces of the hand, somewhat less from the neck and cheeks, and still smaller in relation to the chest and back. According to Galeotti and Macri there is a correspondence, in some parts of the bodies of normal individuals, between the number of the sweat glands and the extent of evaporation from the skin. The parallelism in this respect is, however, by no means complete, so that there is no justification for assuming that the water evaporated is derived solely from sweat glands. Loss of water evidently also takes place through the epidermal layers of the skin, precisely as in the case of the sweat-free subjects of Loewy.

The temperature of the environment often exerts an influence on the evaporation from the cutaneous surfaces in the sense that with increased external temperature the degree of insensible perspiration is augmented. This is, however, not uniformly the case, according to Loewy.[4] He regards the condition of the skin as decisive for the extent of loss of water. With the same external temperature the output will vary with the momentary make-up of the skin, so that it is not regarded as extreme to attribute any influence of the external temperature to its more immediate effect on the cutaneous organ as a whole. In febrile patients the output of water is always greater than in the case of healthy persons.

So far as the loss of water by purely physical processes is concerned, the temperature of the surface layers of the body is the factor of chief importance.

3. Loewy, A., and Wechselmann, W.: Zur Physiologie und Pathologie des Wasserwechsels und Warmeregulation seitens des Hautorganes, Virchows Arch. f. path. Anat., 1911, ccvi, 79.

4. Loewy, A.: Untersuchungen über die physikalische Hautwasserabgabe, Biochem. Ztschr., 1914, lxvii, 243.

5. Galeotti, G., and Macri, N. M.: Ueber die Perspiratio insensibilis unter normalen und pathologischen Bedingungen, Biochem. Ztschr., 1914, lxvii, 472.

Current Comment

HOW DOES URIC ACID EXIST IN THE BLOOD?

Novelties in the domain of uric acid chemistry and physiology continue to attract attention. Some recent studies by S. R. Benedict[1] of the Cornell University Medical College, New York, he believes, indicate the existence of uric acid in at least two forms of combination in the circulating blood. One part is "free" and represents the quota ordinarily determined by the current procedures for the estimation and separation of uric acid in the blood. In addition to this, Benedict has shown that vigorous treatment, such as is represented by hydrolysis with strong hydrochloric acid, makes it possible to obtain a decidedly larger yield of uric acid. This is taken as an indication of a "combined" uric acid. When ox blood, which has been the chief object of study, is allowed to stand in the presence of a preservative, it shows a marked and rapid increase in the "free" uric acid, with a corresponding decrease in the "combined" uric acid. This strongly suggests the possibility of enzyme action leading to a liberation of uric acid from some more complex combination. The magnitude of the different types is indicated by the figures obtained for ox blood, namely a "free" uric acid content of 0.5 mg. per hundred c.c., and a "total" uric acid content of about 7 mg. Perhaps even more surprising is the report by Benedict[1] regarding the distribution of uric acid between the serum and corpuscles. The results show that it is contained quantitatively in these formed elements. The serum seems to be devoid of traces even, in the case of the ox. This is not true in the case of birds, in which, on the contrary, it is present in the serum alone. One must remember, however, that uric acid plays an entirely different rôle in the metabolism of birds, in which it functions as the characteristic and preponderant end-product of nitrogenous metabolism. The facts alone deserve to be cited. According to Benedict, in ox blood the uric acid is for the most part, if not wholly, in combination and within the corpuscles; while in chicken blood, the uric acid circulates free and is contained in the serum. These findings, if

1. Benedict, S. R.: Studies in Uric Acid Metabolism, I, On the Uric Acid in Ox and in Chicken Blood, Jour. Biol. Chem., 1915, xx, 633.

they do not represent some subtle perversity of analytic procedure, call for extensive investigation. Concerning the nature of the alleged combination, the statement is made that it is certainly not protein in nature. If we repeat Benedict's very tentative hypothesis that uric acid, which can be further catabolized, exists in combination in the organism, while that which is to be eliminated as such circulates in the blood in the free state, it must be done with circumspect reserve. This has long been a favorite field for theorizing; and speculation should be subservient to experiment.

FACTS ABOUT RATTLESNAKE VENOM

Although rattlesnake poisoning has lost most of its former prominence as a cause of death in the United States, the toxic agent itself continues to be a source of scientific interest. Certain points in regard to its action have been debated. Thus it has been asserted[1] that the venom of the rattlesnake is toxic to this species itself. Recently, however, Welker and Marshall[2] of the Robert Hare Chemical Laboratory at the University of Pennsylvania, Philadelphia, have injected the fresh poison obtained directly from the living animal intramuscularly into the same species, *Crotalus adamanteus*, without detecting any untoward effects on the snakes. Rattlesnake serum may be somewhat toxic to certain laboratory animals, but not more so than is the serum of other species. It is said that snake venom exhibits little if any toxicity when it is administered by way of the alimentary canal. This has led to the assumption that the bile exerts antitoxic properties on it. Fraser,[3] for example, believed that snake bile had a marked antitoxic action on the venom—an effect exhibited likewise by ox bile in a less marked degree. Welker and Marshall[2] have found that the bile of the rattlesnake is not highly toxic for pigeons, with which they experimented; but they failed to demonstrate the slightest antitoxic power in this secretion.

1. Noguchi, H.: Snake Venoms, 1909, p. 264.
2. Welker, W. H., and Marshall, J.: The Toxicity of Rattlesnake Serum and Bile, with a Note on the Effect of Bile on the Toxicity of Venom, Jour. Pharmacol. and Exper. Therap., 1915, vi, 563.
3. Fraser: Brit. Med. Jour., 1897, ii, 125.

COAL-MINE FATALITIES

Nearly three quarters of a million men are at present engaged in the work of coal mining in the United States. The hazards of their occupation are familiar to every newspaper reader. Many persons fail to realize, however, that aside from the shocking accidents which come prominently into the public notice there are numerous causes of death which are not so often brought to the attention of the world at large. The loss of life in the coal mines is largely due to accidents underground, nine tenths of all the deaths being located there. Most of these are occasioned by falls of roof; many by mine cars and locomotives, by gas explosions and burning gas, and by coal-dust explosions; in lesser number are the underground fatalities by explosives, electricity and diverse other causes. About one tenth of the deaths occur in connection with the shafts and on the surface. In recently published statistics[1] the Bureau of Mines notes that the fatalities in coal mines in the United States in 1914 were 334 less than during the preceding year, the total fatalities being 2,451 as compared with 2,785 for 1913. The saving of one life every day in the year in any industry deserves more than passing notice. The principal causes of fatal accidents that show a material decrease were coal-dust explosions, 96 per cent., haulage 11 per cent., and falls of roof and pillar coal 10.6 per cent. These lower rates cannot be attributed to any single influence. They may, however, be assigned in part to any of the following agencies: closer and more careful inspection by the state inspector; better enforcement of laws and regulations by the operators; the miner's realization of the dangers attending his daily work, and his efforts to reduce accidents, because of the educational campaign conducted in his behalf; the more general use of safety lamps in doubtful mines; the use of permissible explosives; humidifying dusty mines; first-aid and rescue training in accidents which saves lives that might otherwise be lost; the enactment of industrial accident compensation laws and, last but not least, the spirit of cooperation on the part of all concerned. The growing evidence of the progress being made by modern industrial hygiene, even in fields in which inroads have been difficult, is a gratifying sign of the times.

1. Fay, Albert H.: Coal-Mine Fatalities in the United States, During the Calendar Year 1914, Bureau of Mines, March, 1915.

Medical News

(Physicians will confer a favor by sending for this department items of news of more or less general interest; such as relate to society activities, new hospitals, education, public health, etc.)

GEORGIA

Hospital Incorporated.—A petition has been made to the superior court of Screven County for the incorporation of the Screven County Hospital in Sylvania. The capital stock of the institution is to be $15,000.——The superior court of Tift County has received a petition for the incorporation of the Tift County Hospital at Tifton. The purpose of the corporation is charitable and is not organized for individual pecuniary gain.

Hospitals Dedicated.—The hospitals of the University of Georgia, Augusta, were dedicated June 1. The buildings, three in number, have been erected at an expenditure of about half a million dollars. The dedication exercises, which were held in the building, consisted of the presentation of the hospital by the mayor, the acceptance on behalf of the faculty by Dr. William H. Doughty, Jr., dean of the medical college, and an address by the Hon. J. C. C. Black, who paid an eloquent tribute to the physicians and nurses.

Hookworm Campaign.—The state is conducting a systematic campaign against hookworm, with the assistance of the Rockefeller Foundation. It has been decided to carry on the work in future by county organizations and already a number of counties have begun the work. Free examination and free treatment have been provided in a number of counties, and already a large number of persons have taken advantage of this arrangement. That hookworm is not the only parasitic disease prevalent is shown by the examinations of Dr. Charles R. Henry, Atlanta, and J. R. Webb, an assistant, in Gatoosa County, where among 550 persons examined forty-

one were found to have hookworm, forty-two ascaris and thirteen pinworm.

Personal.—Dr. Harry Rubin, Savannah, has been appointed house physician of the Fresh Air Home, Tybee.——The faculty and adjunct faculty of the Atlanta Medical College, which is to be merged next fall with the Emory University, gave a dinner, June 7, in honor of Dr. William S. Elkin, for many years dean of the college, at which a silver loving cup was presented to Dr. Elkin as a testimonial of his services to the college, the presentation address being made by Dr. Stewart R. Roberts, Atlanta.——Dr. George L. Loden, Atlanta, has been placed in charge of the Atlanta Municipal Tuberculosis Sanatorium, Battle Hill, vice Dr. Louis Hollander, Atlanta.——Dr. John C. White, Atlanta, has been appointed surgeon of the North Georgia Brigade, United Confederate Veterans.——Dr. Walpole C. Brewer, Atlanta, sailed for Europe on the *Canopic*, May 8, for the Mediterranean. Dr. Brewer expects to join the American Red Cross unit in Vienna.

ILLINOIS

New Hospital.—The new Belvidere Public Hospital, although not formally opened, is in operation. The institution is located in the Warren Rowan homestead. The president of the association is Dr. Alden Alguire, and the secretary, Dr. H. Eugene Delavergne.

Scarlet Fever at Joliet.—Under date of June 18 more than 200 cases of scarlet fever had occurred in Joliet with two deaths. The town was under strict quarantine and the schools with their 14,000 children were idle. Churches, theaters and other public places were closed and travel to and from the city restricted.

Personal.—Dr. Louis F. Morse, Cobden, is said to have suffered a slight cerebral hemorrhage, June 4.——Drs. John L. Taylor, Libertyville, and John C. Foley, Waukegan, with their families, started on an automobile trip to the Pacific Coast, June 15.——Friends of Dr. William J. Uppendahl, Peoria, gave a dinner in his honor at the Creve Coeur Club, June 7, over which Dr. George A. Zeller presided as toastmaster. Dr. Uppendahl sailed for Europe with the Chicago unit for service abroad.

Health Day in the Legislature.—The secretary of the State Board of Health has named June 16 as Health Day in the Illinois Legislature. On this day in addition to giving final passage to the vital statistics bill and the bill restoring jurisdiction over old licentiates practicing medicine or midwifery, two measures which will have an important bearing on the abortion evil in this state, the following were sent to the governor for signature: a bill for prevention of blindness from infections at birth; a bill relating to garbage disposal in small cities. A drainage bill and one relating to creation of small parks on behalf of the State Board of Health.

Chicago

Rush Graduation.—At the annual graduating exercises of Rush Medical College, June 16, a class of seventy-five was graduated and Dr. Edward Carl Rosenow delivered an address on "Recent Advances in Medical Research."

Alienists and Neurologists Will Meet Next Month.—The fourth annual meeting of the Alienists and Neurologists of the United States, under the auspices of the Chicago Medical Society, will be held July 12 to 17. About sixty papers are already on the program and in addition, there will be a half-day clinic at the city psychopathic laboratory on the morning of July 14, and on the next day an all-day meeting at the Chicago State Hospital, Dunning.

Medical Society Election.—At the annual meeting of the Chicago Medical Society, June 15, the following officers were elected: Dr. A. Augustus O'Neill, president-elect; Dr. Charles E. Humiston, secretary (reelected); Drs. Charles H. Miller, Charles C. O'Byrne, Douglas A. Payne, Fred L. Glenn and Jacob C. Krafft, councilors-at-large; and Drs. John J. Toeller, Edward J. Devine, Rachelle S. Yarros, Sadie Bay Adair and Louis H. Friedrich, alternate councilors-at-large.

Meeting of Rush Alumni.—The annual faculty banquet of Rush Medical College, to the graduating class and almuni, was given June 16. Addresses were made by Dr. J. B. Herrick and President Judson of the University of Chicago in which the development of Rush College as a part of the university was forecasted. Prof. L. Hektoen, acting for the faculty, presented a watch to Dr. E. C. Rosenow, who leaves the faculty to become a member of the Mayo foundation. Dr. B. McPherson Linnell has been elected president of the Rush Medical College Alumni Association; Dr. C. A. Parker, secretary; Dr. Elmer E. Kenyon, treasurer.

Upholds Milk Ordinance.—The provision of the milk ordinance, passed Aug. 14, 1912, requiring that milk must be cooled immediately after production and kept at a temperature not exceeding 55 F. from the cow to the dealer in Chicago, has been upheld in the suit of the city against the Northwestern Railroad Company. The railroad resisted the requirement that the milk must be kept cool while in transit on the ground that the city of Chicago had no power to regulate its traffic, but that such powers were reserved to the State Utilities Commission. The municipal court, Judge Trude, held that this department was a valid exercise of the police power of the city concerning an important food product.

Against Quackery in Advertising.—June 21, in the meeting of the Associated Advertising Clubs of the World, the chairman of the vigilance committee following the lead of the president, William Woodhead, recommended that henceforth quackery and fraud in advertising be held to "strict accountability"; and further that the associated clubs engage a salaried force of lawyers, detectives, physicians, chemists and other specialists to put suspicious advertising through relentless tests for the elimination of unsound factors. The recommendations were endorsed by the executive committee and the national commission and then unanimously by the convention. Subscriptions of over $2,000 were made on the floor of the convention for carrying out the purposes of the recommendations, and will be increased during the meeting.

INDIANA

Philanthropic Physician Dies.—News has just been received of the death on June 18 of Dr. Robert W. Long, Indianapolis, whose benefactions to the state have amounted to $245,000.

Advance in Sanitary Welfare.—The cities of Gary, Valparaiso and Indiana Harbor have appointed all-time health officers and Peru will soon follow their example.——Michigan City has recently established a municipal laboratory.

Personal.—Dr. Edwin G. Kyte, Seymour, has been commissioned as first lieutenant, M. C., Ind. N. G.——A banquet and reception was given at Evansville, June 11, for Dr. George W. Buckner, Evansville, United States minister at Iberia.

Sanatorium Site Bought.—The board of commissioners of Marion County has purchased a tract of ground of 25 acres near Oaklandon, about twelve miles from Indianapolis, as a site for a tuberculosis sanatorium. The cost of the land is $9,228.

MAINE

Meeting of Maine State Medical Association.—The sixty-third meeting of the Maine Medical Association was held at Poland Springs, June 9 and 10, under the presidency of Dr. Herman L. Bartlett, Norway. Portland was selected as the next place of meeting and the following officers were elected: president, Dr. Erastus E. Holt, Portland; vice presidents, Drs. Herbert B. Mason, Calais, and Harry A. Snow, Milo; and secretary treasurer, Dr. John B. Thompson, Bangor.

MARYLAND

Patients Transferred.—The Supervisors of City Charities transferred on May 21, one hundred patients from the City Detention Hospital at Bay View, Baltimore, to the Springfield State Hospital, Sykesville, thus reducing the number of patients at the Detention Hospital. Later a large number of negro patients will be transferred to the Crownsville State Hospital.

Clinic Dedicated.—The John Hubner Psychopathic Building and the Springfield State Hospital, Sykesville, was formally dedicated June 9. The speakers included Drs. Henry M. Hurd, Hugh H. Young and Lewellys F. Barker, Baltimore; Edward N. Brush, Towson, and Dr. Elmer E. Southard, director of the Boston Psychopathic Hospital. Mr. Hubner was presented by his fellow members of the board with a gold-lined silver loving cup.

Personal.—Dr. Thomas S. Cullen, Baltimore, who was operated on three weeks ago for gallstones at the Johns Hopkins Hospital has recovered and left for a Canadian island to recuperate fully.——Dr. John S. Davis of Baltimore, who was operated on for appendicitis by Dr. Richard H. Follis, Baltimore, at the Union Protestant Infirmary, has left the hospital.——Dr. William S. Thayer, Baltimore, who was operated on for appendicitis in the Johns Hopkins Hospital, June 4, left the hospital a week later and will recuperate in the north.

MASSACHUSETTS

Medico-Legal Society Meeting.—The annual meeting of the Massachusetts Medico-Legal Medical Society was held in Boston, June 8, and the following officers were elected: president, Dr. Frederick H. Baker, Worcester; vice-president, Dr. Oliver H. Howe, Cohasset; corresponding secretary, Dr. Frederick H. Thompson, Fitchburg; recording secretary, Dr. Harry M. Cutts, Brookline; treasurer, Dr. A. Elliot Paine, Brockton.

New Health Division.—The commissioner of health has established a new department to be known as the Division of Hygiene and has appointed Prof. Selskar M. Gunn of the Massachusetts Institute of Technology, as its chief. Among the duties of this department will be the direction of child welfare work, public health nursing, the promotion of traveling exhibits, the arrangement of public lectures and the distribution of health bulletins and pamphlets.

Personal.—Dr. Samuel H. Hurwitz, Boston, has been appointed instructor in research medicine in the George William Hooper Foundation for Medical Research of the University of California.——Alexander Swanson Begg has been reappointed secretary of the graduate school of medicine of Harvard University.——Dr. Richard C. Cabot has been appointed medical advisor to Radcliffe College.——Dr. George S. Graham has been appointed second assistant pathologist and Dr. Edgar M. Medler research assistant in pathology, at the Boston City Hospital.

State Society Meeting.—The Massachusetts Medical Society held its one hundred and thirty-fourth annual meeting in Boston, June 8 and 9, under the presidency of Dr. Charles F. Withington, Boston. The Shadduck lecture was delivered by Dr. Joel E. Goldthwaite, Boston, on "The Anatomic and Mechanistic Theory of Disease"; the annual discourse was delivered by Dr. Everett A. Bates, Springfield, on "Perplexities in Modern Medicine." The annual dinner and business meeting was held at the Copley-Plaza Hotel on June 9, and the following officers were elected: president, Dr. Charles F. Withington, Boston, (reelected); vice-president, Dr. Edmond F. Cody, New Bedford; secretary, Dr. Walter L. Burrage, Boston, (reelected); treasurer, Dr. Edward M. Buckingham, Boston, (reelected); and librarian, Dr. Edwin H. Brigham, Boston.

Changes in Massachusetts State Board of Insanity.—According to the Bulletin of the State Board of Insanity, the following changes occurred in the board and various state institutions under the supervision of the board in May: Col. Stanhope E. Blunt, Springfield, trustee of the Monson State Hospital, resigned. The following have also resigned: Dr. Arthur C. Zuck from the Taunton State Hospital, and Dr. Ernest J. Clifford from the same institution; Dr. Egbert W. Fell, first assistant physician, from the Psychopathic Hospital, and Dr. Edward T. Gibson as junior assistant from the same institution; Dr. George E. McPherson from the Foxborough State Hospital; Dr. William T. Hanson as medical inspector of the State Board of Insanity, May 20, to accept the position of physician in charge of the mental wards of the State Infirmary. Dr. Dora W. Faxon was appointed second assistant physician at the Foxborough State Hospital.

MONTANA

Banquet to Medical Society.—The annual banquet of the Fergus County Medical Association occurred May 15 at Lewiston. The dominant topic of discussion was "Unity in the Profession."

Personal.—Dr. Clarke S. Smith, Butte, has started for England for war service.——Dr. Robert E. Hathaway, Glendive, had a narrow escape from death by drowning, May 27, when the automobile in which he was driving plunged into a flooded creek.——Dr. William D. Madden has succeeded Dr. Thomas E. Murray as health officer of Great Falls.

Spotted Fever.—A case of Rocky Mountain spotted fever was reported May 15, from Carbon County, in the person of a farm hand who had been bitten by ticks while getting out timber in the mountains of Wyoming.——Another case was that of a real estate man of Great Falls, who was said to have contracted the infection while in Idaho.——The secretary of the State Board of Health announced, May 15, that there had been reported eighteen cases in the state. The disease is being observed in localities other than the Bitter Root Valley, to which the disease has been confined almost entirely in previous years. Ticks are said to be more plentiful this year than ever.

NEBRASKA

Will Organize Field Hospital.—Dr. Herbert H. Smith, Fremont, has organized at Fremont, a field hospital for the National Guard of Nebraska.

Correction.—Dr. Irving S. Cutter, Omaha, secretary of the College of Medicine of the University of Nebraska, advises that the appropriation made by the legislature for the new state hospital building to be erected on the campus of the college, was $150,000 and not $50,000, as stated in THE JOURNAL of May 22 and May 29.

Personal.—Dr. James D. Case, Dorchester, has been appointed secretary of the State Board of Health and state health inspector, vice Dr. William H. Wilson, Lincoln.——Dr. Hal C. Smith, Franklin, is reported to be seriously ill in a hospital in Lincoln.——Dr. Arthur C. Bunce, Omaha, who suffered amputation of the leg on account of septicemia, has recovered and resumed practice.

NEW HAMPSHIRE

New Officers.—Manchester Medical Society, June 11: president, Dr. Daniel C. Norton; secretary-treasurer, Dr. Melvin P. Badger.

Personal.—Dr. Charles P. Bancroft, Concord, resumed his position as superintendent of the State Hospital, May 17.——Dr. Daniel F. Wells, Exeter, celebrated his seventy-fifth birthday, May 28.

NEW YORK

Diphtheria in Home for Convalescents.—The Caroline Rest in Hartsdale has an outbreak of diphtheria which drove 100 convalescent mothers and their babies back to New York City.

Personal.—Dr. Elmer H. Ormsby, formerly lecturer in anatomy in Albany Medical College, has opened an office in Amsterdam.——Dr. Edmund C. Boddy, Rochester, sailed from New York, June 18, to take service with the Serbian Red Cross.

Memorial Meeting.—The meeting of the Medical Society of the County of Albany, June 10, was devoted to the payment of tribute to the memory of Drs. Samuel Baldwin Ward and George Gustav Lempe, and the adoption of resolutions regarding the death of these two members.

Joint Society Meeting.—A joint meeting of the medical societies of the counties of Allegany, Genesee, Livingston and Wyoming, will be held at Letchworth Park, Portage Falls, July 15. Papers will be read by Drs. Louis F. Bishop and William S. Bainbridge, New York City. Members of all county societies of western New York are invited to be present.

Field Secretary Appointed.—The National Association for the Study and Prevention of Tuberculosis has appointed Mr. Frederick D. Hopkins field secretary, and he will begin work August 1. He is a graduate of Syracuse University and has had experience in publicity and promotion work. He has recently been employed as an inspector by the New York State Board of Charities.

Interesting Number of Health News.—The May number of the *Monthly Bulletin* of the New York State Department of Health is devoted largely to the subject of the diseases of adult life and the increasing mortality at ages over 45. It is said that the statistics show that while the death rate in the periods of early life is decreasing, the rate after 45 is increasing steadily, due almost wholly to the degenerative diseases of the heart, blood vessels and kidneys. It is found that diseases of the heart at present are exceeded only by tuberculosis as a cause of death, and in one or two years the latter was exceeded by the former. Cancer is also on the increase as a cause of death in adult life. Papers by E. L. Fisk of the Life Extension Institute, and on cancer by Curtis E. Lakeman of the American Society for the Control of Cancer, call attention to these facts and emphasize the required measures of prophylaxis, as is also done editorially in the pamphlet and by graphic charts.

New York City

Hospital Physicians Organize.—The assistant attending physicians of the Willard Parker, Riverside and Kingston Avenue hospitals have organized a society for the study of infectious diseases. The first meeting was held at the Willard Parker Hospital May 4.

Hospital Service for Medical Inspectors.—The Municipal Civil Service Commission has agreed to require as a condition of eligibility for the position of medical inspector in the Department of Health twelve months of hospital experi-

ence. An examination for inspectors will be held at an early date.

Dog Muzzling Law Upheld.—The Appellate Division of the Supreme Court in March unanimously sustained the validity of the section of the sanitary code which provides for the muzzling of dogs on any public highway or in any park or place in the city of New York. The test case was known as the Knoblauch case.

Hospital Staff House.—The contract has been let for the erection of the medical staff house and nurses home for the Willard Parker Hospital and the building has been started. The building will be 100 by 83 feet, of concrete fire proof construction and will furnish quarters for thirty-five doctors and 115 nurses, each group being provided a separate entrance, halls, dining room, etc., complete. Swimming pools and gymnasiums will be features of the new building.

Wood Alcohol in Toilet Preparations.—Investigation by the inspectors of the New York City Health Department last year showed that more than one-third of the toilet preparations sold in the city contained wood alcohol, which is forbidden by the Sanitary Code. During the past two months more than 300 preparations taken from barber shops and manicuring establishments and supply houses showed only a small proportion containing this deadly poison. Systematic inspections will be continued.

Personal.—Dr. Benjamin Schwartz has been appointed Coroners' Physician to fill the vacancy caused by the resignation of Dr. Otto H. Schultze.——Dr. William S. Magill returned from Russia June 15.——Dr. William B. Giles sailed June 15 on the *Nieuw Amsterdam* for Falmouth en route for northern France where he is to be surgeon in chief of a British contingent supervised by Dr. Foster Kennedy, New York.——Dr. Frederick Tilney, Brooklyn, has been appointed professor of neurology in the College of Physicians and Surgeons in the city of New York, succeeding Dr. Moses Allen Star, who resigned last month after twenty years of service.——Dr. Ward J. MacNeal has been appointed director of laboratories of the New York Postgraduate Medical School and Hospital, succeeding Dr. Jonathan Wright, resigned.——Dr. Morris Fine has been promoted to adjunct professor of pathologic chemistry; Dr. Richard M. Taylor, to adjunct professor of pathology and Paul A. Schule, to lectureship of bacteriology.

PENNSYLVANIA

Laboratory Installed.—Dr. Francis M. B. Schramm, city bacteriologist of Johnstown, has installed a laboratory on the second floor of the city hall.

Hospital Enlarged.—Plans are well advanced for the enlargement of the capacity of Palmerton Hospital, from fifty to eighty beds. Dr. John W. Luther, surgeon in chief of the institution, is also burgess of Palmerton.

Personal.—Dr. James C. Gray, Cressona, is reported to be seriously ill at his home.—Drs. Louis T. Kennedy and Merchant C. Householder, Pottsville, who have been ill in Chicago, are improving and will soon return home.——Dr. Frederick P. Steck, Shamokin, is taking a trip to the Pacific Coast.

Prize Awarded State Health Department.—A grand prize has been awarded by the International Jury of Awards of the Panama-Pacific Exposition to the Pennsylvania State Department of Health, and Dr. Samuel G. Dixon, commissioner of health, who planned the exhibit, has been given honorable mention.

Philadelphia

Personal.—Dr. S. Lewis Ziegler, director of the Department of Health and Charities, has named Edward A. Lees as assistant director of that department.——Dr. S. Lewis Rubinsohn was operated on at Bushil Sanatorium, June 10.——Dr. William H. E. Wehner has been appointed medical director of the Fidelity Mutual Life Insurance Company, succeeding Dr. William H. King, resigned.

Graduation Exercises.—At the ninetieth annual commencement exercises of Jefferson Medical College, held in the Academy of Music, June 5, the valedictory address was delivered by Dr. Victor Clarence Vaughan of the University of Michigan on the subject, "A Doctor's Ideals."——At the annual meeting of the General Alumni Assocation of the Medico-Chirurgical College of Philadelphia, June 3, the principal address was delivered by Dr. Ernest LaPlace. Dr. William McNeary was elected president and Dr. Charles B. Reynolds, secretary-treasurer.

Fourth of July Precautions.—The safe and sane Fourth committee has planned the distribution of 50,000 pieces of literature to householders and to various schools and institutions, calling on parents and guardians to avoid fireworks. The committee will also have posters placed throughout the city calling attention to the danger attached to the use of explosives. The pamphlet will be illustrated showing a child injured by an explosive and will contain the words, "Will This Happen to Your Child?" Other posters will contain the words, "For Safety's Sake be Sane."

Post-Graduate Teaching Association Organized.—The Cooperative Association for Post-Graduate Teaching of Medicine in Philadelphia has recently been organized by more than 100 practitioners of Philadelphia, with Dr. David Riesman as chairman and Dr. George P. Ruller as temporary secretary. The objects of the association are stated to be to investigate and ascertain the resources for postgraduate teaching that exist in Philadelphia; so to arrange the courses offered by each hospital and college as to enable the students to spend each day in solid study or laboratory work, and the establishment of a central office in charge of the permanent secretary, where rosters of courses may be made and where all information will be listed.

OHIO

Medical Society Revived.—The Preble County Medical Society, which has been quiescent for about two years, has been revived and a meeting was held in Eaton, May 26, to elect new officers and recommence active work.

Health Surveys.—A health survey of Springfield has been commenced by Asst. Surg. L. R. Thompson, and Sanitary Engineer R. E. Tarbett, U. S. P. H. S.——Surg. Carroll Fox, U. S. P. H. S., has completed his health survey of Toledo and returned to Washington.

Room Quarantine Adopted.—After a successful test of the method by Health Officer Daniel W. Iford, Toledo, the city health board has adopted the plan of room quarantine in infectious diseases, and an order has been issued giving detailed quarantine instructions under this method of handling infections. This places the afflicted person in charge of a nurse or other member of the family who must be completely isolated from the other members. The latter are allowed to pursue their usual occupations.

Philadelphians Address Academies.—On May 21, Dr. Richard M. Pearce, Jr., professor of research medicine in the University of Pennsylvania, delivered an address before the Academy of Medicine of Cleveland, on "The Relation of the Spleen to Blood Destruction and Regeneration and to Hemolytic Jaundice." After the lecture a smoker was given at the University Club by the heads of the department of medical research and of the various laboratories of the School of Medicine of Western Reserve University.——Dr. John A. Kolmer, director of the Research Laboratory of Pathology of the University of Pennsylvania, was the guest of the Academy of Medicine of Toledo and Lucas County, May 14, and delivered an address on "The Mechanism and Diagnostic Value of Anaphylactic Skin Reaction."

Personal.—Dr. Thomas G. Farr, the oldest practitioner of South Charleston, was the guest of honor at a banquet before the Clark County Medical Society in Springfield, June 9. After the dinner Dr. Farr was presented by the Society with a leather covered easy chair.——Dr. Harry E. Welch, Youngstown, was elected a vice president, and Dr. Louis H. Frechtling, Hamilton, a trustee of the Ohio Society for the Prevention of Tuberculosis at its meeting in Columbus, June 7.——Dr. Chelsea A. Coleman, Dayton, has filed suit in the common pleas court for $5,000 damages on account of injuries to his legs and damages to his automobile, said to have been suffered May 4, last.——Dr. James H. Lowe, Piqua, has been elected president of the Miami Valley Health Officers Association.——Dr. Louis L. Syman, Springfield, who was operated on for appendicitis at the Springfield City Hospital, June 3, is reported to be doing well.——Dr. Reginald L. Cameron, Cleveland, has been appointed chief surgeon of the Republic Rubber Company and also placed in charge of the welfare department.——Drs. Lucian G. Locke and Charles W. Wendelken, Portsmouth, have been elected trustees of the Antituberculosis Society of Scioto County.

Cincinnati

Portrait Presented.—A portrait of Dr. Joseph Aub, prominent as an eye, ear, nose and throat specialist of Cincinnati, who died in 1888, was hung in the reception room of the

Cincinnati General Hospital, May 28. The painting was presented by the widow of the physician.

New Home for Academy.—Plans for the erection of a new home for the Cincinnati Academy of Medicine to cost $250,000 were discussed at a meeting, June 7. A building committee of five was appointed and it is planned to erect a building on Seventh, Eighth or Ninth streets with one floor for stores, the second, third and fourth floors for offices of physicians and dentists and the upper floors for meeting rooms, library, lecture rooms and laboratories for the Academy of Medicine.

Personal.—Dr. John H. Perry, assistant superintendent of Longview Hospital, has resigned his position to accept a similar post at the Hospital for Criminal Insane at Lima, Ohio.——Dr. Horace F. Tangeman has been appointed otolaryngologist to the Branch Tuberculosis Hospital.——Dr. John A. Caldwell, Jr., has been appointed junior surgeon and Dr. Edgar C. Steinharter, junior gynecologist to the Cincinnati Hospital.——Dr. Albert H. Freiberg has had conferred on him the honorary degree of LL.D. by Cedarville College, Cedarville, Ohio, on account of his distinguished services to humanity in the field of orthopedic surgery.

Emery Gift to the University.—Mrs. Mary M. Emery has made a provisional gift of $250,000 for the construction of a new building for the Ohio-Miami Medical College of the University of Cincinnati, conditional on the raising of a like sum to equip the new building. Mrs. Emery's munificent gift is in gratitude to the profession of medicine and with a desire to further its powers of alleviating the ills of humanity. The new building will be located immediately adjoining the new Cincinnati General Hospital on the north and close to the pathologic building of that institution. The new medical school will consist of a central four-story building and two three-story wings conforming in general architectural plan to the Cincinnati General Hospital. Active work is commenced on the raising of the additional $250,000, on the securing of which, Mrs. Emery's offer becomes available. Mr. Harry M. Levy has already given $50,000 toward this fund.

OKLAHOMA

Health Department Moved to Guthrie.—Permission having been granted by the governor, Dr. John W. Duke, Guthrie, state health commissioner, has moved the office of the State Health Department to Guthrie.

New State Board of Medical Examiners.—Governor Williams has appointed the following board of medical examiners: Dr. Ralph V. Smith, Tulsa, secretary; and Drs. Le Roy Long, McAlester; B. L. Denison, Garvin; Ernest B. Dunlap, Lawton; William T. Ray, Gould; Melvin Gray, Mountain View; and William L. Bonnell, Chickasha.

State Association Election.—At the annual meeting of the Oklahoma State Medical Association held in Bartlesville, May 11 to 13, under the presidency of Dr. John W. Riley, Oklahoma City, the following officers were elected: president, Dr. J. Hutchings White, Muskogee; vice presidents, Drs. Walter Penquite, Chickasha; John P. Sudderth, Nowata, and W. Albert Cook, Tulsa; and delegate to the American Medical Association, Dr. John W. Riley, Oklahoma City. Oklahoma City was selected as the next place of meeting.

Personal.—Dr. David A. Myers, Lawton, is recovering from injuries received when his automobile ran over him while he was cranking it when in gear.——Dr. Henry Cone, Maud, was acquitted on the plea of self-defense at his trial recently for shooting and killing a tenant on his farm. ——Dr. Leander M. Overton, Fitzhugh, was struck by an automobile and sustained a fracture of the skull, clavicle and a Colles fracture.——Dr. Clarence C. Shaw, Tishomingo, has been appointed state prison physician, succeeding Dr. John W. Echols, McAlester.——Dr. Joel R. Holliday, Oklahoma, has been appointed a member of the Board on Sanity, succeeding Dr. Ross D. Long, Oklahoma, who has been given an indefinite leave of absence by county commissioners, and has sailed for Europe.

OREGON

Personal.—Dr. Richard A. Nunn, Portland, sailed for Europe, May 8, and expects to be placed on duty in one of the English hospitals.——Dr. Charles J. Smith, Portland, was elected chairman of the State Board of Higher Curricula at its meeting for organization.——Dr. Shelly Saurman, director of the bacteriologic laboratory of the State Board of Health, has resigned and will locate in Burns.

College Adopts Higher Requirements.—The announcement of the University of Oregon, department of medicine, just received states that after Jan. 1, 1916, two years of collegiate work, including courses in physics, chemistry, biology and French or German, will be required for admission. There are now forty-three colleges and nine state licensing boards which have adopted this higher requirement.

Physicians Win Suit.—The suit brought by Iris W. T. Oliver against Drs. James P. and Brice R. Wallace, Albany, for alleged malpractice in setting a fracture of the shoulder, in which $25,000 damages were asked, was decided May 4, in favor of the physicians. The testimony showed that the treatment of the case was thoroughly scientific and in accordance with the latest and most approved method.

VIRGINIA

Hospital Notes.—The committee on plans for the new Alexandria Hospital has made a contract with an architect of Washington, for the preparation of plans for the building. ——Clergymen of Norfolk have united in a campaign to raise $25,000 to make up the deficit of the Protestant Hospital, Norfolk.

Health Association Meeting.—At the annual meeting of the Virginia Public Health Association, held in Lexington, May 10, to 12, the following officers were elected: president, Dr. John W. H. Pollard, of Washington and Lee University, Lexington; vice presidents, Drs. C. Curtis Hudson, Danville, and Thomas J. Pretlow, Newport News; secretary-treasurer, Dr. W. B. Brownley Foster, Roanoke, and assistant secretary-treasurer, Dr. Roy K. Flannagan, Richmond.

Alumni Election.—At the annual meeting of the Alumni Association of the Medical College of Virginia, Richmond, June 1, the following officers were elected: president, Dr. Lewis C. Bosher, Richmond; vice presidents, Drs. Achilles L. Tynes, Staunton; Thomas S. Hening, Jefferson; William K. McCoy, Gum Spring, and Richard C. Waldon; secretary, Nathaniel T. Ennett, Richmond; assistant secretary, Dr. James H. Smith, Richmond, and treasurer, Dr. Frank H. Beadles, Richmond.

Personal.—Dr. Allen W. Freeman, Richmond, assistant state health commissioner, has resigned to become epidemiologist in the United States Public Health Service.——Dr. Ennion G. Williams, state health commissioner of Richmond, was elected president of the Conference of State and Provincial Boards of Health of North America, at its meeting in Washington, recently.——Dr. William L. Dunn, Abingdon, has been elected surgeon of the William Jones Camp, United Confederate Veterans.——Dr. Harry T. Marshall, Charlottesville, of the University of Virginia, has been appointed a member of the state tuberculosis commission. This commission is to serve without pay and is to consider the question of tuberculosis in all its phases and to report to the next general assembly a comprehensive plan for the control of the disease.

WISCONSIN

Physicians' Building in Green Bay.—Contracts have been awarded for the construction of the Bellin-Buchanan Building, Green Bay. The contract calls for a building 66 by 105 feet and six stories in height, which is to be devoted especially to the use of physicians and dentists.

Hospital Notes.—Dr. Christian U. Senn, Ripon, has associated with him Dr. U. Senn, Milwaukee, and will establish a hospital in the near future. The building at the corner of Ransom and Blossom streets is to be remodeled for this purpose.——A permit has been issued for the construction of an addition to the Milwaukee Hospital for Contagious Diseases, which is to be erected at a cost of $90,000.

Sanatorium Notes.—Ground for a new tuberculosis sanatorium for Kenosha County was broken, May 19, and it is hoped that the construction of the building will be carried on without delay.——The trustees of the Milwaukee County Tuberculosis Sanatorium have asked the people of Milwaukee to suggest a name for the new institution. Suggestions are to be sent to Dr. Hoyt E. Dearholt, Milwaukee.

Personal.—Dr. Urban J. Durner, Milwaukee, has received an appointment as house surgeon in the Eye, Ear, Nose and Throat Infirmary of Middlesex Hospital, London.——Dr. Gustav Windersheim has been reappointed chairman of the Board of Health of Kenosha.——Dr. Frank I. Drake, head physician at the State Prison, Waupun, has succeeded Dr.

Charles Gorst, as superintendent of the Mendota State Hospital.——Dr. Norman Hoffman has been reappointed superintendent of the State Open Air Sanatorium for Tuberculosis, Wales.——Dr. Alfonse F. Kalkhoff, Milwaukee, fell on a sidewalk, recently, fracturing his left arm.——Dr. Gustavus I. Hogue, Milwaukee, has been elected president of the Northwestern Alumni Association of the Southwestern District of Wisconsin.

WYOMING

Personal.—Dr. Henry W. Greist, Casper, is suffering from complete paralysis of the left facial nerve, probably due to exposure.

Tick Fever.—Five fatal cases of Rocky Mountain spotted fever have occurred in Montana this year, to June 4, and there has been a great increase in the number of cases. Ticks are unusually plentiful on account, it is believed, of the extraordinary amount of rain throughout the spring months.

New Quarantine Order.—A new quarantine order, superseding that of April 1, has been issued by the governor. By this order it is permitted to ship into Wyoming, cattle, hogs, sheep and horses from the states of Washington, Oregon, California, Idaho, Nevada, Arizona, Utah, Montana, Colorado, New Mexico and Texas, if accompanied by a health certificate, and from North Dakota, South Dakota, Nebraska, Kansas, Oklahoma, Louisiana, Arkansas, Missouri, Iowa and western Minnesota, on special permit issued by the state veterinarian.

CANADA

Anatomy Professorship Endowed.—Dalhousie University, Halifax, N. S., has received a gift of $30,000 toward the endowment of a chair of anatomy. An announcement is made that this sum will be doubled in the near future.

Sanitary Corps Organized.—Dr. Thomas A. Starkey, Montreal, has organized a sanitary corps for overseas service, of which he will be in command. It will be composed of students of McGill University and will number twenty-eight men. They expect to leave for England shortly.

Ambulance Donated.—The telephone girls of Toronto have presented a motor ambulance valued at $1,800, fully equipped and ready for service to the Canadian Red Cross Society. ——The Hon. Charles Dalton of Charlottetown, P. E. I., has offered to provide a motor ambulance for Red Cross work at the front.

More Surgeons Needed.—The British War Office is asking for more doctors. Candidates must be British subjects, under 40 years of age and graduates of some Canadian medical college. They must pass the regular military service examinations, be members of the Army Medical Corps and vouched for by the authorities of that corps.

Ontario's Offer Accepted.—The War Office has accepted the offer of the Ontario Government to provide a hospital of 1,040 beds in England for wounded soldiers. There have been many applications for positions on this hospital. The following names have been mentioned as likely to receive commissions: Drs. Rowland B. Orr, Herbert A. Bruce, Herbert J. Hamilton and Harry B. Anderson, all of Toronto.

Personal.—Dr. Thomas P. Bradley, Sarnia, Ont., has volunteered for special service overseas with the Royal Army Medical Corps.——Drs. F. W. Manning and Charles R. Totton, Windsor, have been accepted by the Canadian Government for service with the Army Medical Corps in France.——Dr. Irving Heward Cameron, professor of surgery in the University of Toronto, has left for England to accept the position of honorary visiting surgeon on the staff of King George Hospital, an institution with 1,600 beds, recently founded. Professor Cameron will be associated with Sir Frederick Treves, Sir Arbuthnot Lane and other distinguished English surgeons.——Dr. Michel Lefevre, Maisonneuve, Que., has left on an extended trip to California.——Dr. E. Vincent Sullivan, St. Stephen, N. B., has left for Montreal to sail at an early date with the Army Medical Corps for Europe.——Dr. Harris C. Mersereau, Montreal, is going to the front in command of a field ambulance.——Dr. Alfred B. Atherton, Fredericton, N. B., has returned from an extensive trip to California.——Dr. Lorne D. MacIntosh, Hartland, N. B., has sailed for England to act as surgeon in the Imperial Army Medical Corps.——The Hon. Dr. Henri S. Beland, St. Joseph, Que., one time member of the Laurier Government in Canada, has been interned from Belgium where he was when the war broke out. He is now in Germany as a prisoner of war. Dr. Beland had been attending wounded Belgian soldiers in the castle of Capellan.——Dr. James E. M. Carnwarth, Riverside, Hopewell Hill, N. B., had an unusual experience on a recent professional trip returning from a night visit. His motor car ran into two moose lying on the road.——Dr. Harry B. Lawson, Rolling Dam Station, N. B., has departed for Montreal to sail for the war.——Dr. Alan H. N. Kennedy, Macleod, Alta., has been appointed medical referee for the province of Alberta under the Workmen's Compensation Act.

GENERAL

Red Cross Seals.—The American National Red Cross has placed an order for 125,000,000 Red Cross seals for 1915. New regulations in regard to procuring and selling these seals will soon be published in the Bulletin of the Red Cross.

American Surgeons Meet in Minnesota.—At the annual meeting of the American Surgical Association held in Rochester, Minn., June 9 to 11, the following officers were elected: president, Dr. Robert G. LeConte, Philadelphia; vice presidents, Drs. Charles L. Gibson, New York City, and Archibald MacLaren, St. Paul; secretary, Dr. John H. Gibbon, Philadelphia; recorder, Dr. John F. Binnie, Kansas City, Mo.; and treasurer, Dr. Charles H. Peck, New York City. The 1916 meeting will be held in Washington.

Throat, Nose and Ear Specialists Hold Meeting.—At the twenty-first annual meeting of the American Laryngological, Rhinological and Otological Society, held in Chicago, June 10, the following officers were elected: president, Dr. Seth MacCuen Smith, Philadelphia; vice presidents, Drs. William B. Chamberlain, Cleveland; John B. Rae, New York City; Robert C. Lynch, New Orleans, and Thomas E. Carmody, Denver; secretary, Dr. Thomas J. Harris, New York; and treasurer, Dr. Ewing W. Day, Pittsburgh. The gold medal of the society offered for research work was awarded to Dr. G. H. Cox, New York City.

Congress Postponed.—Dr. J. Riddle Goffe, New York City, president of the Seventh International Congress of Obstetrics and Gynecology, announces that the meeting scheduled for September of this year will be postponed until September, 1917. This decision was reached at a meeting of the American Executive Council of the Congress recently held in St. Louis. It was decided that the expenses thus far incurred to the congress should be deducted from the subscriptions of the members of the American Executive Council of America and that the subscriptions of all other members of the organization committee should be returned to them until money is again needed in the preparation for the congress.

New Regulation Under the Harrison Narcotic Law.—The following bulletin has just been issued by the Commissioner of Internal Revenue, interpreting Regulations No. 35, Supplement No. 2, of the Harrison Narcotic Law, requiring a separate application for registry and payment of special tax if the applicant has more than one place of business, with no exception.

Art. 1. The second paragraph of this article is hereby amended, effective on and after this date, to read as follows:

If the applicant has more than one place of business, or if, in any case, the applicant is engaged in more than one profession or business where any of the drugs above described are made, stored, or dispensed, a separate application for registry must be made, and a special tax must be paid, in each such case.

Bequests and Donations.—The following bequests and donations have recently been announced:

For the establishment of a hospital in Bluffton, Ind., $1,000, by the will of Herman Wicking, Ridgewood, N. J.

Chicago Lying-In Hospital, $100,000, from Mrs. Julius Rosenthal.

Maine General Hospital and Maine Eye and Ear Infirmary, Portland, each $50,000, contingent bequests by the will of John E. Martin.

St. Louis Skin and Cancer Hospital, the income of the estate of George D. Barnard, appraised at $2,000,000.

Montefiori Home and Mount Sinai Hospital, New York City, each $10,000; United Hebrew Charities, Guild for Crippled Children and New York Skin and Cancer Hospital, each $2,500, by the will of Mrs. Amelia Lavenburg.

St. John's Hospital, Brooklyn, N. Y., $2,000, by the will of Mrs. Julia E. Beals.

Episcopal Hospital, Philadelphia, $5,000, for the endowment of a free bed to be known as the William H. Richardson free bed, by the will of Alice H. Richardson.

St. Joseph's Hospital, Philadelphia, $5,000, for the endowment of a free bed in memory of the late Rear Admiral Jackson McElmell, U. S. N.; St. Agnes' Hospital, Philadelphia, $5,000, to endow a free bed in the name of the testator by the will of Thomas A. McElmell.

West Philadelphia Hospital for Women, donations of $5,000 each, from Miss Mary Burnham and Miss Elizabeth Shippens, and $1,000 by the will of Mrs. Theodore Lewis, all to be devoted to the Maternity Building fund.

Presbyterian Hospital, New York City, $30,000, by the will of Mrs. Evelina A. Meserole.

Red Cross Work in Mexico.—Two carloads of food sent by the American Red Cross to Monterey, Mexico, have been received and greatly appreciated by the starving people. More than 20,000 have already been fed.——Corn for 7,000 was supplied at the American Hospital at Monterey, on June 5.——Corn, beans and rice are the most urgent needs.——General C. A. Duval, general manager of the American Red Cross, has been conferring with Major-General Frederick Funston, regarding the direction of the Mexican relief campaign. He also visited the various border points to expedite and safeguard the handling of relief stores.——Consular agents throughout Mexico will cooperate with the Red Cross and the military authorities on the border in the forwarding of supplies.——Two additional cars of corn have been sent to Monterey.——The American Red Cross shipped on June 10, twenty-five cases of drugs and hospital supplies to the United States consul at Vera Cruz, to be forwarded to the Spanish, American and French hospitals in Mexico City.——Famine conditions are said to prevail at Vera Cruz and in the surrounding country.——At Jalapa conditions are said to be appalling. More than 2,500 women stood in line for the distribution of rations.——Acapulco, on the west coast, is practically without food supplies and the inhabitants are reported to be starving.——Shortage in all cereals is reported all over Mexico and in Mexico City, thousands are said to be in danger of perishing from hunger and epidemic diseases.——Smallpox and typhus fever are reported to prevail in the city of Mexico.

The Campaign Against Cancer.—The American Society for the Control of Cancer urges every state medical society to take an active part in arranging meetings for the spread of the latest knowledge among members and the public of malignant disease. The Pennsylvania State Medical Society has suggested that medical journals help in the propaganda and many of them will devote their July issues to the cancer problem. The American Society has recently restated its relation to the cancer campaign and to the various other organizations working along the same line. The national society has endeavored to work in harmony with other agencies and so to arrange its work and organization as not to duplicate efforts in cancer prevention. It organizes no local societies where existing agencies cover the field, and will not attempt to enter the field of biologic research already so well covered under the auspices of the leading universities. The society expects, however, to expand that feature of its work relating to the collection and collation of statistical data, which need to be improved both as regards their collection and publication. At the suggestion of the society the United States Census Bureau immediately began the preparation of a report on the cancer mortality in the United States registration area in 1914. In this report the deaths will be stated in detail under some thirty titles of organs and parts of the body affected, rather than, as hitherto, under the six general groups of the international list. This will conform to the plan of the Imperial Cancer Research Fund, making the data available in the same form as those of England and Wales. The bureau will also attempt to make a distinction between returns based on certain and on doubtful diagnoses, and to establish this is making inquiry of physicians reporting cancer cases as to whether the diagnosis was based on clinical findings alone or was established by surgical operation, microscopic examination or necropsy. Much of this work, it is believed, should be done in the first instance by registration officers or the boards of health of the various states where the original certificates of death are filed. The society urges on the various state officials the need of doing this work in order to insure the permanence of the improvement in the statistical study of cancer which has been inaugurated by the census bureau. The society is further interested in and will give special attention to special statistical studies of the geographic, racial and occupational distribution of cancer, and endeavor to collate on a uniform plan the records of the surgical treatment of the disease in the leading hospitals so that an authoritative answer may be available to inquiries as to what percentage of success is to be expected in the treatment of cancer in each of its phases and stages.

WAR NOTES

Swedish Hospital at Paris.—The Swedish colony in Paris has established a hospital within the premises of the Swedish church in the rue Guyot. The *British Medical Journal* states that the hospital makes a specialty of Swedish massage by experts. Dr. Périer is in charge of the hospital.

Typhus Conquered in Serbia.—Advices to the *British Medical Journal* of June 5 confirm the news that the epidemic of typhus in Serbia is now virtually extinct. On April 5, there were 8,198 cases of typhus at Nish and by April 18, only 948. The number of cases of relapsing fever had dropped from 7,693 to 4,861.

Philadelphia Unit Leaves for War.—The University of Pennsylvania expedition composed of doctors and nurses led by Dr. J. William White, sailed from New York, June 12, on the *St. Louis* for work in the American Ambulance, Paris. The medical members of the party are Drs. James P. Hutchinson, chief surgeon; Daniel J. McCarthy, neurologist; Drs. Edmund B. Piper, Arthur E. Billings and Peter M. Keating, assistant surgeons; Dr. Samuel Goldschmidt, bacteriologist; Drs. Thomas Galler and D. M. Davis, assistants, and four nurses.

Armenian Red Cross Fund.—Armenia joins Russia in the eastern part of Asia Minor, and 10,000 Armenian volunteers are now fighting in the Russian army. This number will soon be doubled, but they have no medical men except a few medical students from Kieff. Armenians all over the world have equipped and maintain the soldiers, but there are no Red Cross appliances of any kind. Thousands of refugees have crossed the border into Turkestan, 12,000 are known to be at one point. An appeal for a Red Cross and Refugee fund for the Armenians is published in the *Lancet*; the treasurer is Mr. H. A. Godson Bohn, 17 Holland Villas Road, Kensington, England.

New Motion Picture on Tuberculosis.—It is announced in the Bulletin of the National Association for the Study and Prevention of Tuberculosis that after several months of work the association, in cooperation with the Universal Film Co., has produced a new four-reel film called the "White Terror." It is said to be a production with "dramatic punch," carrying several lessons concerning the use of fake cures for consumption, the danger of bad housing and working conditions and the evils of political corruption as it relates to public health. As this film will be distributed in the regular service of the film company, which supplies half the theaters in the United States, it will be seen by a large number of persons.

The Touring Club and the War.—The efforts in recent years of the organized automobilists of western Europe to improve the roads have proved of signal service in the military operations in the last few months. The headquarters of the Touring Club of France are in the magnificent premises where was kept the safe supposed to contain the fabulous fortune of the Humberts. The members of the club are mostly fighting at the front, and the building has been devoted to the preparation of packets of gifts to be sent to the men on the firing line. Souvenir postcards, medals and little flags were sold to add to the funds for this purpose, all commemorating the big gun, "the seventy-fiver." They were sold by the thousands of members of the Touring Club for a few pennies each, and the *Lancet* states that special arrangements had to be made with the banks to deal with the huge amounts of small coins thus turned into the treasury of the club. Far over a million dollars had been realized by the first of June, and the reports are not all in.

Aid for Belgian Physicians.—The report of the treasurer of the committee of American physicians for the aid of the Belgian profession, for the week ending June 19, 1915, lists the following contributions:

Dr. L. O. Tarleton, 1st Lieut. U. S. A., Manila, P. I.	$ 5.00
Norwich Medical Association, Norwich, Conn.	25.00
Westmoreland County Medical Society, Mount Pleasant, Pa.	25.00
Elmira Academy of Medicine, Elmira, N. Y.	50.00
Dr. Angus McLean, Detroit, Mich.	30.00
Receipts for the week ending June 19	$ 135.00
Previously reported receipts	7,312.00
Total receipts	$7,447.00

Previously reported disbursements:

1,625 standard boxes of food at $2.20	$3,575.00	
1,274 standard boxes of food at 2.30	2,930.20	
353 standard boxes of food at 2.28	804.84	
Total disbursements		7,310.04
Balance		$ 136.96

F. F. SIMPSON, M.D., Treasurer,
5 Jenkins Arcade Bldg., Pittsburgh, Pa.

Repair after Wounds of the Jaws.—The *Lancet* reproduces an account of a visit to the Strassburg hospital where a

staff of specialists is striving to reduce to the minimum the ravages caused by wounds of the mouth and face. It is said to be the first that has ever been organized in any war for the treatment of wounds of the face and jaw. "The staff numbers fifty-five, and all the work (including the cooking), which is done by the wives and daughters of the professors, is performed without fee. The hospital itself is divided into two sections. In the first a dozen dentists examine the teeth of the soldiers, extract, and make plates. This work is carried out at the cost of the military authorities, who adopt the very reasonable point of view that a soldier with defective teeth cannot be thoroughly efficient. The remaining section of the hospital itself comprises two subdivisions—the operating theater and the department in which are made the prosthetic molds destined to replace the bones or sections of bone sacrificed in the operation, and the surgical work is entirely done by dentists, most of whom have taken their medical degree. The wounded are photographed and roentgenographed on their arrival and photographed before departure, and these photographs and roentgenograms will constitute a collection of the highest scientific interest." At the moment of the visit more than 200 soldiers were undergoing treatment there, and the results already obtained are said to be almost marvelous.

BERLIN LETTER

BERLIN, May 26, 1915.

Visit to Camp of Prisoners of War

A party of 400 Berlin physicians, May 25, visited the camp of war prisoners installed near Berlin on the large parade ground at Döberitz. About 9,500 prisoners are quartered there, housed in new wooden barracks, partitioned off. The camp is laid out in blocks, and the prisoners are quartered by nationalities.

Although the requirements as to food differ according to the nationality, the profession and other individual peculiarities, yet nowhere were visible signs of insufficient nourishment. Not a few of the captives appeared excellently well nourished. As is easily understood, the living rooms and especially the sleeping quarters are primitive. The governments now have to care for 1,400,000 prisoners in the various concentration camps. The prisoners keep in the open air almost all day long, and the open windows and doors provide for ample ventilation. Everywhere we found good air in the barracks.

All the prisoners are obliged to keep themselves clean. Each one is compelled to take a shower-bath every day, a simple but well-working shower-bath arrangement being installed in each barracks. Every three weeks the clothing of each of the prisoners is sterilized with hot air. There is a huge central establishment for washing the body linen, and in each block there is a separate wash-house where the captives can clean their clothes and linen.

Each captive receives daily 300 gm. of bread, with coffee, tea or soup in the morning; at noon, one-fourth liter soup, with vegetables, potatoes and 100 gm. meat; for supper, soup, with sometimes tea or chocolate. There is a cook-room in each block, where the meals are prepared in four large kettles. Near the cook-room there is a bar or canteen where articles of food and clothing and sewing materials are for sale at fixed, very low prices. Most of the captives are able to supplement the regular ration served out to them as they receive donations forwarded to them from their homes. A special pavilion is devoted to this package service, eight officials receiving and carefully examining the parcels and handing them over to the prisoners.

There are four latrines to each block. The cement floors of the closets are flushed with a perpetual flow of water sweeping the excreta at once into the sewer, so that there are no disagreeable odors in or around the latrines.

ARRANGEMENTS FOR THE SICK

Three pavilions in the camp shelter the sick, one for internal medicine, one for surgery and one for contagious diseases. Besides these there is an isolation pavilion, fifteen minutes' walk from the camp. The health of the Döberitz camp is very good; there were only nine inmates in the medical ward and ten in the surgical, none very sick, and the contagious pavilion was empty. In the isolation pavilion there were a few tuberculous French prisoners. Two Russian and two English army surgeons have charge of the sanitary and hygienic care of the prisoners.

HOW THE PRISONERS PASS THE TIME

At present there are only 3,500 captives in the camp, as 6,000 are being utilized in farm work in the neighborhood. The captives still in camp are also occupied in farm or road work or called on for service inside the camp. In special cases more freedom is allowed, as, for instance, in one small building where several artists are at work, painting portraits and other pictures, paints having been supplied them by gifts from friends at home. A large tent has been set up for a Russian theater, the stage setting artistically adorned by some of the Russian prisoners. There is a similar institution also for the English, and we had the peculiar pleasure of hearing an orchestra of English prisoners render the overture to Don Giovanni. The orchestra is only partly composed of professional musicians.

PARIS LETTER

PARIS, June 3, 1915.

The War

A NEW IMPROVEMENT IN THE TRANSPORTATION OF THE WOUNDED

The transportation of the wounded, which was the weakest side of the organization of the medical service at the beginning of the war, has since then been considerably improved. The removal of the wounded has been so far accelerated that at noon, April 29, soldiers who had been wounded at the Yser on the 28th were received at the station of La Chapelle, which is the distributing point for the entrenched camp of Paris. This progress is due in part to the greater number of medical service trains. There are at present more than 200 of these. It is also partly due to a change in method. For many months wounded men were transported like ordinary passengers, being fed and their wound dressed at the station infirmaries. Now there are three kinds of medical service trains: (1) trains called permanent, which are composed of special coaches for the exclusive use of the wounded; (2) trains called semipermanent, which are composed either of baggage cars arranged for reclining wounded men or of passenger cars with a side aisle (these coaches are arranged to receive both seated and reclining wounded men); (3) trains called improvised, made up of coaches or of baggage cars fitted up with apparatus for suspending litters and intended to receive wounded men who are unable to sit up (these last trains are utilized only for intensive evacuations).

To make of each train the hospital on wheels demanded by the medical service, however, certain indispensable features must be provided. The departmental instructions prescribe only the addition to the train of a restaurant car, which is to serve as an office, a pharmacy, a dressing room, a diet kitchen and a dining room for the staff. This solution, which answered as a makeshift during a period of transition, is really unsatisfactory. It is impossible to adapt to such various uses a single restaurant car. Moreover, each one of these cars weighs 37 tons. To carry one of them three coaches of wounded men must be omitted. Something better, therefore, is required. Commandant Carcenat, commissary officer of one of our stations, has endeavored to solve the problem. He has devised the transformation of an ordinary baggage car 9.5 or 10 meters (31 or 33 feet) long into either a dining car or a hospital car. The dining car comprises the kitchen, with stove, coffee urn, cupboard and pantry, and a dining room for sixteen men. The cost of fitting it up is about 800 francs ($160). The hospital car comprises three rooms: (1) a diet kitchen with a very small water heater surrounded by asbestos, capable of boiling 200 liters of water in an hour (this permits the preparation of hot drinks and of aseptic dressings at any hour of the day or night); (2) the pharmacy, containing indispensable remedies such as morphin and caffein, ampules of cocain and ether and antitetanic and antidiphtheric serums; (3) a very simple dressing room, but arranged according to all hygienic rules with an operating table composed of two tripods connected by a cross bar on which the litter is placed. Every soiled object is thrown into the furnace of the locomotive at the first stop. The cost of fitting up a baggage car as a hospital is about 1,100 francs ($220).

To increase the number of these moving hospitals as much as is desirable outside assistance is permitted. The city of Paris has just fitted up, at its own expense, seven baggage cars as kitchen and dining cars. The city of Lyons has done the same. Societies and private persons can easily collect the amount necessary for such refittings.

RESULTS OBTAINED AT THE SCHOOL FOR CRIPPLES AT LYONS

I mentioned in my previous letters (The Journal, March 13, 1915, p. 923, and May 15, 1915, p. 1671) various endeavors which have been made to reeducate cripples for vocations. M. Edouard Herriot, mayor of the city of Lyons and senator of the department of the Rhone, has just reported the results already obtained in the first Ecole professionelle de blessés at Lyons. The school has at present ninety-three pupils, eighty-five resident and eight nonresident. It gives instruction in the following subjects: (1) bookkeeping, stenography, typewriting, etc.; (2) shoemaking; (3) sewing; (4) carpentry and joinery, and (5) bookbinding. It is also proposed to lay out extensive grounds for the instruction of some of the war cripples in horticulture.

All the pupils employed in manual labor are obliged to give their evenings to courses of general instruction graded according to the previous education of the pupils.

The purpose of the school is to produce not merely passable workmen but model workmen, and to combat the tendency of crippled soldiers to seek for wretched little government jobs. In order to keep the pensioners as long as may be necessary to teach them the complete technic of their trade and permit them to become teachers, employers or foremen, they are given substantial inducements; that is, they are given free board, no claim being made on the allowance made them by the government, and at the same time they are permitted to receive the returns from their daily work.

IMMEDIATE TREATMENT OF WOUNDS OF WAR BY CONCENTRATED SOLUTIONS OF SEA SALT

At a recent session of the Société de chirurgie de Paris, Dr. Abadie of Oran reported good results obtained by treating wounds with concentrated solutions of sea salt which, being hypertonic, produced an exosmosis, thus bathing the tissues while promoting diapedesis. These solutions, unlike antiseptics, are not toxic for the cellular elements. After the wounds have been freely laid open and carefully cleansed, removing the dead and suspected tissues, Abadie irrigates freely with a 0.7 per cent. solution of sea salt and then packs the wound with gauze wet in the mother solution of from 14 to 28 per cent. A thick dressing is necessary because of the abundant serous effusion. This mode of treatment gives red and healthy wounds, in which infections are aborted at the start. Old wounds are deodorized and the general condition is not comparable to that ordinarily presented by severe wounds.

Dr. Morestin, surgeon of the hospitals of Paris and agrégé, has also made much use of salt but not in precisely the same conditions as those reported by Abadie. He has used it especially in the treatment of old wounds and particularly of varicose ulcers. The salt rapidly modifies wounds which are atonic or covered with exuberant granulated tissue. It gives them a healthy appearance and hastens repair. This treatment, however, has the disadvantage of being painful.

THE DANGER OF PUTTING TYPHOID AND PARATYPHOID PATIENTS IN THE SAME WARD

At a recent session of the Société médicale des hôpitaux de Paris, Drs. Jeanselme and E. Agasse-Lafont reported a case of successive infection first by the paratyphoid B bacillus and then by the Eberth bacillus, which raises an important problem of prophylaxis. A soldier brought back from the front who had been infected with paratyphoid B was placed in an isolation ward in which there were both typhoid and paratyphoid patients. The case first ran a normal course and then seemed to have a relapse, which was followed by a second relapse. The possibility was then considered of the complication being not a relapse but a new infection. Serodiagnosis with the Eberth bacillus, which had been negative during the first attack, was now found distinctly positive.

This fact seems to indicate that typhoid and paratyphoid patients should be separated, the two groups of patients being dangerous to each other, since the two diseases are absolutely distinct and neither immunizes against the other, as has been proved by vaccination. Prudence is all the more desirable since cases of paratyphoid are now extremely frequent, being even more numerous in certain regions than cases of true typhoid.

AN AMERICAN FIELD HOSPITAL

A field hospital of the type used in the American army has just been exhibited in Paris. It is due to the generosity of the Fahnestock family of New York. It consists of twenty-two khaki-colored canvas tents. Eight conical tents are for the use of the staff. Six oblong tents are to be used for the wounded; each tent can receive eighteen so that there is a capacity of 108 wounded. Five hospital tents have a double covering, a circulation of air between the two layers of canvas maintaining an even temperature within the tents. Three of these five are for operation rooms; the fourth is used as a pharmacy and the fifth is for the reserve medical appliances. Three tents are intended each to accommodate two officers. These twenty-two tents and their contents are placed on four trucks furnished by the French government. To this unit, which is about to go to the front, are attached ten large automobiles belonging to the American hospital of Neuilly. Each of these cars can carry four or five wounded men sitting and three who are unable to sit up. The great utility of this ambulance will be in seeking out the wounded at the first aid post behind the line of fire and transporting them rapidly after the first dressings to the stations.

PHYSICIANS WHO HAVE RECEIVED THE DECORATION OF THE LEGION OF HONOR

Among the physicians serving in the army whose names have been inscribed on the roll of the Legion of Honor are a certain number of professors and agrégés of our medical schools. Two of these nominations deserve particular mention. Dr. Chavannaz, professor of clinical surgery at the Faculté de médecine de Bordeaux, head physician of the ambulance of the army corps "has insisted, in spite of his age, on performing campaign duty; he has rendered the greatest services to the wounded by his operative skill and his organizing talent." Dr. Paviot, professor of pathologic anatomy at the Faculté de médecine de Lyon, "has, since the beginning of hostilities, directed an evacuation hospital under difficult circumstances with a technical competence and an initiative which are equalled only by his absolute devotion to the service."

LONDON LETTER

London, June 4, 1915.

The War

GERMAN AIR RAIDS

German airships have dropped incendiary bombs on Southend, on the estuary of the Thames, causing fires which were promptly extinguished, but not without the loss of lives of several women and children. They also reached some of the outlying parts of London with a similar result. Four adults—three women and one old man—and two children have perished. The incendiary material used is "thermit," which was originally a mixture of equal parts of iron oxid and finely divided aluminum. This mixture may be ignited by a match of magnesium wire ending in a small quantity. When started in this manner, the ignition spreads through the whole of the mixture, reducing the iron oxid to metallic iron, with formation of aluminum oxid, and evolution of an amount of heat sufficient to melt the iron. Thermit has been largely used to weld wrought and cast-iron objects and to mend fractures in machinery, the operation being carried out by surrounding the point to be welded with a metallic box filled with thermit. Better results have been obtained by modifications of the original formula, in which powdered aluminum and calcium, or a powdered alloy of these two metals, are used instead of aluminum alone.

THE WAR MEDICAL SERVICE

In his presidential address to the General Medical Council, Sir Donald MacAlister reviewed the position created by the great demand for surgeons of the new armies. He pointed out that our professional reserves, at no time large, have been drawn on to the full. Throughout the kingdom, organized efforts are in progress for such readjustments of civil practice as will liberate all who can possibly be spared for the medical service of the navy and army. In these efforts, the Scottish Emergency Committee and local committees of the British Medical Association, with the effective cooperation of members of this council, have taken a leading part. The services of qualified women have been freely offered and accepted for many of the places that are now vacant at home. Senior students enrolled in the combatant ranks have been recalled by the War Office and directed to complete their curriculum with a view to qualification for the Royal Army Medical Corps. From overseas have come

large numbers of our colonial colleagues, who are possessed of qualifications registerable in this country, and so are eligible for commissions in our army. Owing to a special regulation of the council, about sixty Belgian doctors of medicine have become legally qualified to practice in Britain and to occupy professional positions in public and other institutions. From all these sources we have obtained timely and valuable help, but they must be supplemented. If we are to make good the losses in the Army Medical Service we must accumulate larger reserves. The casualty lists and the lists also of awards for conspicuous gallantry testify to the magnitude of these losses. Inquiries as to the number of students actually in attendance on courses of medical study at the several schools show that, at the end of 1914, there were considerably over 1,000 fewer than in 1913. The recall of senior students from active service has had a favorable effect on the year now drawing to a close, but we must expect during the next few years a falling off of about 250 per annum in the number who become qualified as medical practitioners. Surgeons in Canada have been desirous of coming to the aid of the mother country, but have been hindered by difficulties connected with their local registration laws. Sir Donald MacAlister communicated with the various medical authorities concerned, and the response has exceeded all his expectations. From Ontario, British Columbia, Saskatchewan, Manitoba and Alberta came messages stating that legislation had already been initiated for the removal of existing provincial restrictions, and that the provinces desired that reciprocity with this country might be established at the earliest possible date. When the necessary steps are completed—and he has reason to think that no obstacles need be apprehended on this side of the Atlantic—all the provinces of Canada will have severally entered into reciprocal relations with the United Kingdom, the way will be open for the application of the medical act to the dominion as a whole, and the medical federation of the empire will be accomplished.

THE INCREASE OF WOMEN PHYSICIANS

The great increase in the number of women physicians in this country—from two, forty years ago, to over 1,000 at present—is reflected by the enlargement of the London School of Medicine for Women, at a cost of $100,000. Sixty new students will join the school in October, and the pressure on the space in the laboratory at which 220 are working is already very great. The increase in the number of women physicians was in progress before the war, but has been greatly accelerated by the shortage of men physicians produced by it.

INCREASE OF CANCER

The annual report for 1913 of the registrar-general, which has recently been published, unfortunately confirms the view that cancer is increasing. The deaths from this cause were greater in 1913 than in any previous year on record. The mortality among males was equal to 947 per million living, and among females to 1,155 per million, compared with rates of 913 and 117, respectively, in the year 1912. The tables show a constantly increasing mortality in proportion to urbanization, which is more serious in the case of males than females. According to the registrar-general, Dr. Stevenson, differences of the dimensions shown may be due to the better facilities for diagnosis in the urban areas, where a much larger proportion of the deaths occur in institutions in which postmortem examination is the rule, than, as in private practice, the exception. The considerable increase of mortality now recorded is very uniform, being common to the two sexes in every class of area. It is also widely spread over the different age periods, the chief exception being in the case of women at very advanced ages. The excess of female mortality over that of males is concentrated mainly on the ages from 25 to 55. At other ages there is either practical equality or a male excess, as at ages from 60 to 85 in the country generally. The increase of mortality from cancer of various organs differs. In both sexes the most rapid rates of increase are furnished by cancer of the alimentary tract, especially the intestines and stomach. Diseases of the female breasts also claim a rapidly increasing number of victims, while mortality from uterine cancer is diminishing. Childbearing appears to increase the risk of uterine and diminishes that of mammary cancer. The mortality from cancer of the liver remains stationary. Secondary growths are mentioned with especial frequency in cases of breast cancer. Deaths thus certified amount to 33 per cent. in the case of the breast, whereas in the case of most other important sites the proportion falls short of 10 per cent.

Marriages

WILBURN H. SMITH, M.D., to Mrs. Clara Rood Royce Akeley, both of Long Beach, Cal., at Santa Barbara, Calif., June 10.

FRANK HARMAN SMITH, M.D., Clintonville, Ky., to Miss Maude Hooser of Crowder, Okla., at Jeffersonville, Ind., June 2.

EDGAR FLOYD SEWELL, M.D., Somerville, Mass., to Miss Edna Florence Gordon of West Somerville, Mass., June 9.

MATTHEW HAMMOND GRISWOLD, M.D., Kensington, Conn., to Miss Vermadel Rodgers of Burlington, Vt., June 24.

JEREMIAH MILTON NEWMAN, M.D., Philadelphia, to Miss Ora Arneta Johnson of Richmond, Va., Dec. 2, 1914.

CLARKE JACKSON STALLWORTH, M.D., Thomaston, Ala., to Miss Mary Carter Adams, at Consul, Ala., May 19.

THOMAS GRIER MILLER, M.D., Philadelphia, to Miss Sarah H. George of Baltimore, in Philadelphia, June 3.

JOSEPH FRANCIS MELOAN, M.D., Media, Ill., to Miss Josephine Michael Block of Elsberry, Mo., June 1.

IRVING GEORGE WILTROUT, M.D., Swanville, Minn., to Miss Louise Schaefer of Two Rivers, Wis., June 5.

CHARLES MORGAN WILLIAMS, M.D., to Miss Jane Little Willison, both of Washington, N. J., June 8.

LEO ALBERT GOODMAN, M.D., Dubuque, Ia., to Miss Mary Cecelia Downey of Hammond, Ind., June 12.

THOMAS JEROME HENNEBERRY, M.D., Cheyenne, Wyo., to Miss Fredrika Dolcater, at Denver, June 2.

NORBERT CHARLES NITSCH, M.D., to Miss Ethel Marie Katzenberger, both of Baltimore, June 23.

CONSTANTINE J. MCGUIRE, JR., M.D., to Miss Alice M. Cordier, both of New York City, June 10.

CHARLES TAYLOR MOSS, M.D., Champaign, Ill., to Miss Lillian K. Christoph of Chicago, June 14.

CLYDE LE GRANDE SEITZ, M.D., to Miss Florence Elizabeth Heitshue, both of Glen Rock, Pa., June 2.

LOUIS F. MOLLEUR, M.D., to Mrs. Frank Reynolds, both of Melrose, Mont., in Butte, Mont., recently.

ELMER D. MADDUX, M.D., LaCrosse, Ind., to Miss Ethyle Schriver of York, Pa., in Chicago, June 3.

JAMES RUSSELL STEWART, M.D., to Miss Belle Williams, both of Colorado Springs, Colo., June 17.

THOMAS EDWARD CONLEY, M.D., Park Ridge, Ill., to Miss Ellen May Raynor of Chicago, June 21.

GEORGE TRAYLOR EDWARDS, M.D., Elba, Ala., to Miss Annie Lou Dudley of Mulberry, Ala., June 2.

FRANK MONTGOMERY, M.D., Denver, to Miss Claire Le Walien of Manhattan, Kan., April 29.

JOSEPH IRVING LIND, M.D., New Haven, Conn., to Miss Stella A. Mann of Baltimore, June 7.

CHARLES CLEVELAND ADAMS, M.D., to Miss Madge Campbell, both of Longview, Tex., June 5.

JOHN WESLEY CLAYTON, M.D., Johnston City, Ill., to Miss Agnes Doty of Marion, Ill., June 2.

PAUL CLEMENTS, M.D., Culion, P. I., to Miss Trinidad Munoz, at Manila, P. I., April 11.

RUDOLPH E. J. OBEN, M.D., Cadillac, Mich., to Miss Olga Wahlquist of Minneapolis, June 8.

BURGOYNE H. GIBSON, M.D., Richmond, Ky., to Miss Mattie E. Lewis of Hyden, Ky., recently.

ANDREW SARGENT, M.D., Hopkinsville, Ky., to Miss Isabelle D. King of Philadelphia, May 5.

ROY ALVIN SCHNACKE, M.D., to Miss Thursnelda Abetmeyer, both of St. Paul, June 22.

GEORGE STANLEY BARBER, M.D., to Miss Alma Lucile Fain, both of Lawton, Okla., June 9.

CHARLES OTTO MOORE, M.D., to Miss Josephine Durkee, both of Salt Lake City, June 3.

WALTER SAULSBURY NIBLETT, M.D., to Miss Ethel Wolfe, both of Baltimore, June 9.

WILLIAM H. MARTIN, M.D., to Mrs. Anna P. Doyle, both of Houston, Tex., June 1.

HENRY JAMES, M.D., to Miss Rosalie O'Brien, both of New York City, June 8.

Deaths

Charles Edward Woodruff, M.D. Jefferson Medical College, 1886; lieutenant-colonel, U. S. Army (retired); who entered the Navy as assistant surgeon in 1866 and a year later transferred to the Medical Corps of the Army; an officer of distinguished service and awarded two medals for war service; author of several books and monographs, the best known of which are probably his work on, "The Effects of Tropical Light on White People," which appeared ten years ago, and his treatise on "Medical Ethnology," which appeared last month; a Fellow of the American Medical Association; assistant editor of *Modern Medicine;* died at his home in New Rochelle, N. Y., June 15, aged 54.

Charles Elihu Slocum, M.D. College of Physicians and Surgeons in the City of New York, 1869; Bellevue Hospital Medical College, 1876; Jefferson Medical College, 1876; at one time president of the Defiance County (Ohio) Medical Association and vice president of the District Medical Society; for several years professor of psychology and ethics in the Cleveland College of Physicians and Surgeons; at one time vice president of the Merchants' and First National banks at Defiance, Ohio; for many years a resident of Toledo; died in the Flower Hospital in that city, June 7, aged 74.

Jacob Michaux, M.D. Medical College of Virginia, Richmond, 1876; a member and once president of the Medical Society of Virginia and also president of the Richmond Academy of Medicine and Surgery; professor of materia medica and therapeutics in the University College of Medicine, Richmond, from its foundation in 1893 until 1912; assistant surgeon and later surgeon of the First Infantry, Virginia Volunteers; in 1889 appointed a member of the State Medical Board; one of the most prominent practitioners of Richmond; died at his home in that city, June 7, after a long illness, aged 63.

Abraham Barker Cates, M.D. Harvard Medical School, 1880; a Fellow of the American Medical Association and professor of obstetrics in the College of Medicine and Surgery of the University of Minnesota, Minneapolis; one of the leaders in the efforts in behalf of the Elliott Memorial University and the Trast Endowment; obstetrician to the Northwestern, Asbury and Swedish hospitals, Minneapolis, and attending physician to the Bethany Home; died at his summer home in Clearwater Lake, Minn., June 10, aged 61.

John Hildreth McCollom, M.D. Harvard Medical School, 1869; formerly a Fellow of the American Medical Association; a member of the Massachusetts Medical Society and American Society of Pathology and Bacteriology, and American Pediatric Society; emeritus professor of contagious diseases in his alma mater, and medical director of the Boston City Hospital; died at his home in Boston, June 13, aged 71.

Arthur Worrall Palmer, M.D. New York Homeopathic Medical College, New York City, 1883; surgeon and professor of laryngology at the New York Ophthalmic Hospital; laryngologist to the Metropolitan Hospital, New York City; formerly editor and publisher of the *Journal of Ophthalmology, Otology and Laryngology;* died at his home in New York City, June 10, aged 52.

Joseph Walker Floyd, M.D. Medical College of the State of South Carolina, Charleston, 1900; a member of the South Carolina Medical Association and Medical Society of the State of North Carolina; chairman of the board of trustees of the Tabor (N. C.) Graded School; a veteran of the Spanish-American War; died at his home in Tabor, June 4, from cerebral hemorrhage, aged 41.

Henry Janes, M.D. College of Physicians and Surgeons in the City of New York, 1855; a Fellow of the American Medical Association; surgeon of Volunteers during the Civil War in which he served as brevet lieutenant-colonel; at one time in command of the hospital ship *Maine*; and surgeon-general of the state of Vermont; died at his home in Waterbury, Vt., June 10, aged 82.

Henry Osborn Hanawalt, M.D. Medical College of Ohio, Cincinnati, 1873; professor of organic nervous diseases in the University of Kansas, School of Medicine; a veteran of the Civil War; at one time president of the Kansas Medical Society and the Jackson County (Mo.) Medical Society; died at his home in Kansas City, June 5, aged 70.

George B. Graves, M.D. University of the South, Sewanee, Tenn., 1903; formerly a member of the State Medical Association of Texas; formerly surgeon to the Virginia Pocahontas Coal Company, Coalwood, W. Va., and a member of the West Virginia State Medical Association; died at his home in Valentine, Tex., June 7, aged 34.

William Wabash Kneale, M.D. University of Virginia, Charlottesville, 1889; a member of the Indiana State Medical Association; for four years a member of the common council of Anderson, Ind.; physician to the American Steel and Wire Company; died at his home in Anderson, June 7, from cerebral hemorrhage, aged 54.

Lee Whitfield Staton, M.D. Kentucky School of Medicine, Louisville, 1879; of Richmond, Va.; acting assistant surgeon, U. S. P. H. S., for eighteen years; aged 58; a member of the Association of Military Surgeons of the United States; was thrown from his buggy, June 7, fracturing his skull and died fifteen minutes later.

James Small, M.D. American Medical College, Eclectic, St. Louis, 1880; resident physician to the Nuyaka Mission School, I. T., in 1890-1891; for many years a practitioner of north Arkansas, south Missouri and eastern Oklahoma; died at his home in Steedman, Okla., April 18, from pneumonia, aged 73.

Hal Laureston Speedy, M.D. Western Pennsylvania Medical College, Pittsburgh, 1911; formerly intern in St. John's Hospital, Pittsburgh, but for the last six months, assistant superintendent of the Santa Fe System hospital at Albuquerque, N. M.; died in Albuquerque, June 3, aged 29.

Maurice J. O'Connor, M.D. Northwestern University Medical School, Chicago, 1903; of Williams, Ia.; was crushed under his overturned automobile, near his home, June 7, and died a few hours later in St. Joseph's Mercy Hospital in Webster City, Ia., from his injuries, aged 38.

Powhattan Green Trent, M.D. Jefferson Medical College, 1867; a member of the Medical Association of the State of Alabama; formerly president of the Randolph County (Ala.) Board of Censors; died at his home in Roanoke, Ala., May 31, from heart disease, aged 70.

Amos T. Davis, M.D. Cincinnati College of Medicine and Surgery, 1859; formerly of Flat Rock, Ind.; died in his barrack at the National Home for Disabled Volunteer Soldiers, National Military Home, Ind., April 5, from acute dilatation of the heart, aged 79.

Edward Ellerslie Goodman, M.D. Jefferson Medical College, 1874; for forty years a practitioner of Altoona and at one time physician of Blair County; died at his home in Altoona, June 1, from cerebral hemorrhage, aged 65.

Thomas B. Ross, M.D. Washington University, St. Louis, 1866; a veteran of the Civil War and for thirty years a practitioner of Saline County, Mo.; died at his home in Slater, Mo., March 11, from sclerosis of the brain, aged 81.

James Edward Rankin, M.D. Keokuk (Ia.) Medical College, 1891; of Watertown, Ill.; died in the Watertown State Hospital, June 6, from the effects of poison, self-administered, it is believed, with suicidal intent, aged 46.

Ianthus G. Johnson, M.D. Albany (N. Y.) Medical College, 1853; for more than sixty years a practitioner of Greenfield Center, N. Y.; supervisor of the town of Greenfield for two years; died at his home, June 1, aged 85.

John Werton Hampton, M.D. Rush Medical College, 1912; of Norway, Mich.; physician for the Loretto (Mich.) Mining Company; died in St. Joseph's Hospital, Chicago, June 3, from lymphatic leukemia, aged 26.

Karl A. Norderling, M.D. College of Physicians and Surgeons, Chicago, 1887; formerly of Chicago, but since 1908 a resident of Paxton, Ill.; died at his home in that city, June 9, after a long illness, aged 58.

John Fullilove Taylor, M.D. Vermont Medical College, Woodstock, 1853; of Holly Grove, Ark.; a Confederate veteran; died at the home of his daughter in Little Rock, Ark., May 29, aged 81.

Edward F. Lake, M.D. Syracuse (N. Y.) University, 1882; of Denver; died at his home in that city, June 10, from malignant disease of the throat after an illness of more than two years, aged 55.

Daniel G. Allinder, M.D. University of Pennsylvania, Philadelphia, 1869; a veteran of the Civil War and formerly a practitioner of Pittsburgh; died in Washington, D. C., May 28.

William Henry Stettler, M.D. Bellevue Hospital Medical College, 1891; of Spinnerstown, Pa.; died in the German Hospital, Philadelphia, June 8, from strangulated hernia, aged 45.

Ross V. Dickey, M.D. Eclectic Medical Institute, Cincinnati, 1899; county physician of Allen County, Ohio; died at his home in Lima, June 9, from cerebral hemorrhage, aged 46.

John Tinsley Harrison, M.D. Atlanta (Ga.) Medical College, 1881; a member of the Medical Association of the State of Alabama; died at his home in Talladega, Ala., May 27, aged 81.

George Henry Hutchings, M.D. Eclectic Medical College of the City of New York, 1884; a practitioner for more than fifty years; died at his home in Woburn, Mass., May 30, aged 74.

Matthew Joseph McKenna, M.D. Long Island College Hospital, Brooklyn, 1912; Bay Ridge, Brooklyn; died at the home of his uncle in Brooklyn, June 4, from nephritis, aged 24.

George W. Loar, M.D. Physio-Medical Institute, Cincinnati, 1863; for nearly half a century a resident of Monroe, Ia.; died at his home, March 23, from pneumonia, aged 69.

William Webster Small, M.D. Ohio Medical College, Cincinnati, 1873; formerly of Indianapolis; died in Loomis, Calif., May 5, from chronic inflammation of the spleen, aged 64.

Alfred H. Metts (license, Indiana, 1897) of Fort Wayne, Ind.; a practitioner for nearly half a century; died suddenly in Ossian, Ind., June 4, from heart disease, aged 77.

Roy Earl Mauldin, M.D. Mississippi Medical College, Meridian, 1912; of Artesia, Miss.; aged 27, was shot and instantly killed by a druggist of that place, June 3.

John Blair Guthrie, M.D. University of Toronto, 1889; an advertising specialist of Illinois; died at his home in Evanston, Ill., June 5, from tuberculosis, aged 45.

Benedict Jones Wetherby, M.D. Rush Medical College, 1884; a Fellow of the American Medical Association; died at his home in Wilkes-Barre, Pa., May 28, aged 55.

John Gants, M.D. Eclectic Medical Institute, Cincinnati, 1872; for fifty-nine years a practitioner of Cromwell, Ind.; died at his home in that place, June 2, aged 82.

Orlando C. Stewart, M.D. University of Maryland, Baltimore, 1878; formerly of Cookport, Pa.; died at his home in Toledo, Ohio, June 2, from heart disease.

Samuel Elliott McCreary, M.D. Miami Medical College, Cincinnati, 1880; died in his office in Keokuk, Iowa, May 28, from cerebral hemorrhage, aged 58.

John Frederick Harrington, M.D. Keokuk (Iowa) Medical College, 1895; of Stacyville, Ia.; died in St. Francis' Hospital, Waterloo, Iowa, June 2, aged 53.

William P. Parr, M.D. Jefferson Medical College, 1859; died at his home in Wichita, Kan., April 6, from chronic diarrhea and rheumatism, aged 82.

M. D. Dunham, M.D. Chattanooga (Tenn.) Medical College, 1903; died at his home in Georgetown, Tenn., June 6, from heart disease, aged 60.

Thomas Burke Walsh, M.D. University of Illinois, Chicago, 1912; died at his home in Artesian, S. D., June 3, from heart disease, aged 30.

Franklin J. Clay Griffith, M.D. Cincinnati College of Medicine and Surgery, 1874; died at his home in Annapolis, Ill., May 27, aged 71.

Jesse Dwight Bacon, M.D. American Medical College, Cincinnati, 1856; died at his home in Cannelton, Ind., June 9, aged 83.

Isaac R. Landis, M.D. Jefferson Medical College, 1865; died at his home in Philadelphia, May 29, from nephritis, aged 74.

Isaac H. Kelly, M.D. College of Physicians and Surgeons, Keokuk, Ia., 1880; died at his home in Stone Fort, Ill., May 27.

Joseph Prevett (license, Massachusetts, 1904), an Italian practitioner of Boston; died in Derry, N. H., June 6, aged 34

The Propaganda for Reform

IN THIS DEPARTMENT APPEAR REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY AND OF THE ASSOCIATION LABORATORY, TOGETHER WITH OTHER MATTER TENDING TO AID INTELLIGENT PRESCRIBING AND TO OPPOSE MEDICAL FRAUD ON THE PUBLIC AND ON THE PROFESSION

ARTICLES REFUSED RECOGNITION

Report of the Council on Pharmacy and Chemistry

Below appear abstracts of the Council's action on articles refused recognition which were not deemed of sufficient importance to require a lengthy report.

Venodine

Venodine (The Intravenous Products Co., Denver), according to information sent to the Council, is "an Intravenous Iodine Compound" put up in ampules each of which contains "28 grains of Sodium Iodide, ⅛ grain each of Beechwood Creosote and Guaiacol in a suitable vehicle, and excipients to enhance its compatibility with the circulating blood."

The "Therapeutic Indications" include "infectious diseases, such as syphilis, tuberculosis, bronchitis, bacteraemias associated with chronic and acute nephritis (Bright's disease), and other infections." The Council held as unwarranted and grossly exaggerated the following therapeutic claims: (1) that the full therapeutic value of iodin medication cannot be readily obtained except by intravenous injection; (2) that Venodine is "of exceptional value in tuberculosis"; (3) that in pneumonia Venodine "combines the anaesthetic properties of creosote and guaiacol with the germicidal value of iodine"; (4) that "Venodine (or its iodine component) has long enjoyed an exceptional reputation" as of great value in many infectious diseases including bacteremias. The facts on these points are the following:

1. Since iodids are easily absorbed from the mucous membrane of the gastro-intestinal tract and are usually well tolerated by the stomach, there is no reason for resorting to intravenous injection in their administration.

2. The indiscriminate administration of iodids for pulmonary tuberculosis is strongly to be condemned. The cases in which they can be given to tuberculous patients without doing harm must be very carefully selected.

3. There is no evidence either that creosote is excreted by the lungs in sufficient quantity to exert an anesthetic influence or that iodin is present in the circulation of the lungs or in the bronchial secretions in a form which is capable of exerting any germicidal action whatever.

4. It is generally held that the systemic administration of iodin compounds in bacteremias is useless.

The Council also held the name "Venodine" objectionable in that it fails to indicate the chief ingredient (sodium iodid) of this simple pharmaceutical mixture. The statement in a circular that "Venodine is a sterile solution representing 1.54 Gm. (24 grains) of iodine in chemical combination together with creosote and guaiacol" is likely to lead physicians to use the preparation without considering that its chief constituent is the well-known substance sodium iodid, particularly so since no reference to sodium iodid is made in the circular.

Furthermore, the Council held that the combination of two such similar substances as creosote and guaiacol (the second a constituent of the first) as given in the published formula, stamps Venodine as unscientific; it adds mystery to the preparation, but does not increase its efficiency, and is therefore against the best interests of the public.

The Council voted that Venodine be held ineligible for conflict with Rules 6, 8 and 10.

This report having been submitted to the manufacturers, in accordance with the Council's custom, and the reply affording no reason for modifying the findings, its publication has now been authorized.

Calcreose

In response to inquiries and in view of the extensive advertising propaganda, the Council, on Dec. 19, 1913, took up for consideration Calcreose (Maltbie Chemical Company, Newark, N. J.). Examination showed that the preparation contained, in loose combination, approximately equal weights of creosote and lime. The claims made in the advertising

"literature" were extravagant and uncritical, and the Council therefore held Calcreose ineligible for New and Nonofficial Remedies.

In June, 1914, at the request of the Maltbie Chemical Company, the Council undertook a reconsideration of the preparation. The advertising claims were now found more conservative. Before the existing claims could be judged, however, the Council deemed it necessary to require from the company satisfactory proof (1) that the large doses of Calcreose recommended and administered actually furnish large amounts of creosote to the blood, and (2) that patients taking these large doses do not suffer from digestive disturbances, loss of nutrition, albumin in the urine or phenol urine, as claimed. The Council accordingly advised the company of this requirement, at the same time stipulating that nothing in the report should be interpreted as indicating a belief on the part of the Council that enormous doses of creosote are necessary for, or will promote a cure of tuberculosis.

The Maltbie Chemical Company has not up to the present date furnished this proof, but has evinced a disposition to make the Council's holding Calcreose under advisement appear in the guise of a quasi-approval. It is therefore recommended that Calcreose be refused recognition for conflict with Rule 6.

Standard Radium Solution for Intravenous Use

Standard Radium Solution for Intravenous Use (Radium Chemical Co., Pittsburgh) is sold in ampules each containing radium bromid equivalent to 0.05 microgram radium element and 0.0002 gm. or less of barium bromid dissolved in 2 c.c. sterile normal physiologic salt solution.

While the Council has confirmed the claimed composition of Standard Radium Solution for Intravenous Use so far as concerns the radium content, it refused recognition to the preparation because there is no clear evidence that intravenous injection has any advantage over the other methods of administering radium. The Council holds that radium for internal medical use is in an experimental stage, that, on the basis of our present knowledge, this substance should be used intravenously only by those in a position to study its effect carefully, and in an institution equipped with the necessary facilities for such study. For these reasons and on account of the risk involved with any form of intravenous medication, the Council voted not to accept Standard Radium Solution for Intravenous Use for inclusion with New and Nonofficial Remedies.

In accordance with the Council's regular procedure this report was submitted to the Radium Chemical Company for comment. The Council, after considering the new evidence offered, decided that its previous action should be allowed to stand and accordingly authorized publication.

Rheumalgine

Rheumalgine (Eli Lilly & Co., Indianapolis) is put up both in tablet form and as a liquid. Each tablet, or teaspoonful of the liquid, is said to contain:

"Strontium salicylate from Natural Oil..... 5 gr.
Hexamethylenamin ..... 2 gr.
Colchicine ..... 1/200 gr."

The advertising matter contains several statements regarding the individual ingredients to which objection must be made.

It is claimed (quoting from Hare) that strontium salicylate

". . . is not so disagreeable to the taste as the corresponding sodium salts, and more important still, it is far less apt to disorder the stomach."

"Taste" is a difficult subject to dispute; but in the experience of the referee patients object more to the strontium than to the sodium salt. No evidence is submitted to prove that the strontium salt is less apt to disorder the stomach. In observations made under the direction of the referee, the nauseant and emetic doses are about the same as, or even less than, those of sodium salicylate.

Under hexamethylenamin, the recommendations are not confined to its recognized use as a urinary antiseptic; it is also said to be "unexcelled" as a "germicide," and to prevent the formation of urate and phosphate deposits. These statements are contrary to facts.

"Rheumalgine . . . may be used in all cases where the salicylates are indicated. It is superior to preparations containing sodium salicylate, in that it does not cause nausea or disturb the digestion."

Both the preceding statements are misleading. The necessity of giving 1/200 grain of colchicin for each 5 grains of salicylate would certainly interfere with the use of adequate doses of the latter. The colchicin would produce digestive disturbance quite apart from the salicylate.

The mixture is described as:

". . . ANTIRHEUMATIC, ANTIPYRETIC, URINARY ANTISEPTIC, AND URIC ACID ELIMINANT. Useful in Acute Articular and Chronic Rheumatism, Muscular Pains, Lumbago, Sciatica, Migraine of the Rheumatic, Gout, and in Nervous Irritability of the Gouty or Lithemic."

The facts are: Salicylates are useful in some of these conditions, colchicin occasionally in a few, hexamethylenamin in none. The combination is conducive to uncritical prescribing. For instance, salicylates are effective in acute articular rheumatism; hexamethylenamin and colchicin are useless; salicylates are of very little use in chronic rheumatism, sciatica and nervous irritability, while hexamethylenamin and colchicin are useless in these conditions; colchicin is sometimes effective in gout, salicylates perhaps also; hexamethylenamin is not.

Attention should also be called to the high dosage of colchicin, namely, 1/100 to 1/50 of a grain of the alkaloid, every three or four hours, the dose then to be "slightly reduced," but continued for several days; or in chronic cases, 1/100 to 1/30 grain per day, continued indefinitely. This dosage appears high, if a really active preparation is used.

Finally, the name "Rheumalgine" encourages thoughtless and unscientific prescribing. If a mixture is used at all, the prescriber should be constantly reminded of its composition.

It is therefore recommended that Rheumalgine be held in conflict with Rules 6 (unwarranted therapeutic claims), 8 (non-descriptive name) and 10 (unscientific composition).

Correspondence

Cancer and Heredity

To the Editor:—In Dr. Slye's recent communication (The Incidence and Inheritability of Spontaneous Cancer in Mice. *Jour. Med. Research*, 1915, xxxii, 159) concerning the inheritance of cancer, reference is made by way of illustration to a type-color inheritance which, since it is quite contrary to the more generally accepted principles of mendelian inheritance, requires critical comment.

On page 160 she says, "Let me at this point recall some of the basic facts of heredity." She then proceeds, using the customary mendelian terms "dominant" and "recessive," to describe a cross between *gray and albino mice*, and indicates results which are incompatible with those of other investigators. She furthermore furnishes no data in support of this more or less revolutionary hypothesis.

As Castle, Allen, Bateson, Durham, Cuenot, Plate, Davenport, and many others have carried on investigations on this particular problem in genetics and have reached results contrary to those predicted by Slye, it seems reasonable to demand a full presentation of her data on the inheritance of *albinism* in mice. In fact, a careful repetition of such work should be expected before her claims are to be accepted.

To those unfamiliar with the work of the geneticists above mentioned, Slye's paper might be taken as presenting the well-known principles of mendelian inheritance. With a knowledge of the facts, however, it is obvious that the type of inheritance which she outlines has not been observed in similar material by any of the investigators above mentioned. That this discrepancy is not based on an oversight on the part of Miss Slye has been determined by personal correspondence.

C. C. Little, Boston.
Cancer Commission of Harvard University.

[The foregoing letter was referred to Dr. Slye who writes:]

To the Editor:—Dr. Little's criticism is of course concerned wholly with a dispute on questions of mendelian interpretation. Such a dispute in no way affects the validity of my

results in cancer. Unfortunately, at the present time there is so much difference of opinion on almost every point in the mendelian doctrines that one could scarcely put out any results which would satisfy all the adherents of the different hypotheses.

The production of about a thousand spontaneous cancers in specified strains, and the nonoccurrence among this entire number of any cancer in certain other specified strains, no matter what test is applied to them, demonstrates to every reasonable probability the inheritability of cancer, and when these results are characteristically and systematically obtained in such an immense stock as to furnish over 10,000 necropsies and a living stock of about 11,000 mice, with a steady production of between seventy-five and a hundred cancer patients all the time and almost without exception within proved cancer strains, this reasonable probability is raised to an almost indisputable fact; and whether or not my strains of house mice have behaved in hybrid crosses in accordance with the established canon has no bearing whatever on the behavior of cancer. This question lies in quite another field.

In regard to my use of the terms "dominant" and "recessive" with respect to cancer behavior: It is almost the established conviction today that these terms are descriptive and not dynamic, and they furnish in the description of the behavior of cancer in heredity a graphic and convenient tool. That is probably all they furnish in the exposition of any problem in heredity. They may be discarded for even that service within the next few years.

The chief value in the study of cancer of the use of a partial mendelian background of comparison (although the details may be under dispute) is to show to those most interested how far back in a strain cancer may lie and still be transmitted, and by what sorts of crosses this can be done; and to make it plain that in deciding on the inheritability of human cancer and of the method of elimination of cancer from a family, one cannot take as a criterion of judgment whether or not the immediate parents exhibited cancer.

I do not desire or make a strict mendelian interpretation of my results; indeed, I should deplore such an interpretation. I have used mendelian comparisons (1) to make clear the influence of a more or less remote ancestry on later generations of progeny; (2) to show how cancer, like albinism, has been transmitted in my strains through generation after generation *by individuals who did not exhibit it;* and (3) to demonstrate how cancer thus transmitted finally leaps into expression in the offspring of a pair neither of whom expresses cancer, but both of whom bear it potentially.

The approximation even to conservative mendelian results is strikingly close for such a characteristic as cancer.

MAUD SLYE, Chicago.
The Otho S. A. Sprague Memorial Institute.

The Notary Fee in Applications for License Under the Harrison Narcotic Law

To the Editor:—I have just received notice from the collector of internal revenue that my application for a license, under the Harrison Narcotic Law, must be sworn to before a notary before it is sent to him.

It seems to me that we ought to make a strong protest against this very unjust rule. The fee for this service is from twenty-five to fifty cents, depending on the location. Usually it is fifty cents, which is not a very large sum; but in the aggregate it will amount to many thousands of dollars, and for what good? Absolutely none, except for the notary.

We have all complied with the law, and our licenses were duly paid for and issued for the four remaining months of the fiscal year. No notary fees were required for that. Every physician in the country entitled to use, prescribe or dispense any drug coming under the law is on record at his respective collector's office. The penalty for violation of the law in any way is very severe; therefore, why this unjust fee?

HENRY F. HOYT, M.D., Long Beach, Calif.

Kaolin, Clay Eaters and Clay-Containing Streams

To the Editor:—Noting in THE JOURNAL of June 12 editorial and other reference to the subject of the adsorption, perhaps by virtue of colloidal states of solution, by kaolin, I write to suggest that, in light of the work on its effect on the intestinal bacteria, investigations of the peculiar physiologic or pathologic state of the "clay eaters," numerous in some localities (North Carolina mountains) would be interesting. Especially would this be interesting in connection with the thought and the slight amount of experimental evidence of the possibility of life without the ingestion or the presence in the intestinal canal of micro-organisms.

Entirely aside from all but its physicochemical bearing is the curious condition of the river waters in many of the Southern streams. Even when practically motionless, they seem to hold in suspension indefinitely the whole or a considerable part of the finely divided clay particles of the soil of the territories which they drain. Much attention has for years been devoted to the fluvial waters and drinking water generally by the Italians, lately especially in connection with the etiology of pellagra. It might be that a study of the questions involved would result in considerable advance in our knowledge of many obscure problems of intestinal metabolism.

JONATHAN WRIGHT, M.D., Pleasantville, N. Y.

A "Twilight Sleep" Exhibit

To the Editor:—We have recently had presented in our city films representing "twilight sleep," accompanied by a lecture by a "German doctor." It purports to be under the auspices of the "Motherhood Educational Society." A committee of the Civic League of Saginaw, after seeing it in Bay City, protested against its presentation here—vainly, however, as the mayor found nothing objectionable in either pictures or lecture, and rebuked the women who objected to the commercial exploitation of maternity.

The lecturer subtly attacked the medical profession throughout. At the close, he invites questions from the audience. A good opportunity to test the reaction of the production is thus afforded. Some of the questions were offensive; on these the lecturer waxed witty, and there was hilarity in a considerable part of the audience. Aside from the question of bad taste, his statements were absolutely untrue. He claimed that twilight sleep was successful in 90 per cent. of all maternity cases.

What can be done to prevent such mischievous presentations to mixed audiences?

I have read with interest THE JOURNAL of May 22 with its reports of scopolamin-morphin treatment. In the light of such reports, a production such as was presented here is misleading and harmful in every way.

MRS. ELIZABETH S. CURTIS,
The Civic League, Saginaw, Mich.

Possibility of Failure in Prophylactic Typhoid Vaccination

To the Editor:—The following case is instructive from the standpoint of surgical diagnosis:

Miss X, aged 21 years, a nurse in Hahnemann Hospital, complained of anorexia and malaise for three days, at the end of which time she was suddenly taken with general abdominal pains. There was neither nausea nor vomiting. Her temperature was 102.4 F., pulse 120 and respirations 20. The white cell count was 12,000. The next morning, Dec. 27, 1914, the temperature was 103 F., the pulse 118, and pain and tenderness were localized in the right iliac fossa. Inquiry developed the fact that she had previously received immunizing injections of typhoid vaccine in another hospital as follows: Oct. 12, 1914, 500 million; Oct. 22, 1914, 1,000 million; Nov. 2, 1914, 1,000 million. The first dose was administered by the resident physician, the second by the supervising nurse and the third by a nurse in training. No ill effects whatever were experienced from the injections. In view of

these past facts and present symptoms, the case was diagnosed appendicitis, and operation performed. The findings in the appendix did not satisfy the diagnosis, and the case was closely watched. The temperature continued between 103 and 104 F. and the pulse above 110. December 28, the leukocytes were 11,600. December 29, a blood culture in glucose bouillon was negative. December 31, the Widal reaction, as was anticipated from the previous immunization, was positive. December 31, a second blood culture in bile was positive for the typhoid bacillus. Jan. 4, 1915, the leukocytes were 5,400, and rose spots appeared. The patient ran an average typhoid course, without complications, to recovery.

While the value and efficacy of typhoid immunization are undisputed and difficult to overrate, and while occurrences as cited are probably very rare, the foregoing experience may be timely and valuable in emphasizing the fallacy which seems to prevail in medical circles, namely, that recent typhoid immunization entirely eliminates typhoid fever in questions of abdominal diagnosis. The great mass of conclusive figures in favor of prophylactic typhoid vaccination are apt to blind us to the possibility of its failure in a certain very small percentage of cases for reasons which should be carefully inquired into.

S. W. SAPPINGTON, M.D., Philadelphia.

Queries and Minor Notes

ANONYMOUS COMMUNICATIONS and queries on postal cards will not be noticed. Every letter must contain the writer's name and address, but these will be omitted, on request.

POSTSACRAL SINUS

To the Editor:—As I have been unable to find anything in the books at my disposal, I should consider it a favor if you would give me some information on postsacral sinus, its etiology, pathology, prognosis and treatment. C. C. I.

ANSWER.—The term "postsacral sinus" has no specific meaning, as a sinus in the postsacral region may be due to a variety of causes as, for instance, osteomyelitis of the sacrum or coccyx of tuberculous or other origin; tuberculosis of the sacro-iliac joint, or of the hip, etc. Excluding bone or joint trouble of this kind, the most frequent cause of a sinus in this region is a persistence of the blastopore, or neurenteric canal, one of the earliest fetal canals extending from the surface of the embryo near the caudal end to the notochord.

This canal usually entirely disappears at a very early period of fetal life. There is almost always a small dimple in the lower sacral or coccygeal region which marks the point of the blastopore. Occasionally the blastopore fails to disappear entirely, a small tract of varying length remaining lined with epithelium. This little tract may be closed on the surface, in which case a small cyst may develop filled with sebaceous material. The cyst may become inflamed, open and discharge the sebaceous material, when a little sinus will persist.

Again, the blastopore may fail to close, in which case an epithelial-lined sinus of congenital origin may be present; or the tract may open on the surface at some later time of life, and a sinus persist. A similar condition is occasionally found at the umbilicus, because of a persistence of the omphalomesenteric duct.

The proper treatment of these sinuses is simply to remove the epithelium-lined tract.

BURNS OF THE EYE FROM LIME

To the Editor:—Please give the most approved method of treatment for the common and serious accident of getting lime in the eye. I have known several persons who have lost their eyesight completely from this accident, and I have been unable to find a book that even touches the treatment in a case of this kind. F. E. P.

ANSWER.—This form of accident occurs quite frequently, and is apt to be followed by very grave results. The most serious and important sequel is the adherence of the lid to the globe (symblepharon) when there are two opposing raw surfaces. If the patient is seen immediately after the accident, the first step in the treatment is to drop into the conjunctival sac a few drops of a 1 per cent. solution of holocain, or of a 4 per cent. solution of cocain, in order to relieve the pain, which is usually intense, and then to remove all the remaining particles of lime as quickly as possible. The irrigating fluid should be a weak solution of vinegar, to neutralize the caustic effect of the lime. Subsequently cold applications should be applied to the closed lids, and a mild antiseptic, such as a 3 per cent. boric acid solution, dropped into the eye every two or three hours. If the burn is at all extensive, the conjunctival sac should be filled with an antiseptic ointment, which not only relieves the pain, but also prevents adhesion of the opposing surfaces. One of the best preparations for this purpose is a mercuric chlorid ointment which consists of mercuric chlorid (1:10,000) in petrolatum. Severe burns from lime, resulting in complete opacity of the cornea, have been treated—in addition to the usual local treatment—by subcutaneous injections of sodium cacodylate (from 3 to 7 grains at a dose) with perfect results. For the general practitioner who, in emergencies like this, should be prepared to treat conditions which ordinarily belong to the ophthalmic surgeon, a practical book is "The Commoner Diseases of the Eye," by Wood and Woodruff. It takes up only the diseases of the eye most frequently seen, and how to detect and treat them, without technical discussion.

REFERENCES ON DISEASE OF THE PITUITARY GLAND

To the Editor:—I want to find out all I can concerning the effect of disease of the pituitary gland. Does this gland have any effect on the growth of the body? I am particularly interested in the case of a boy, aged 17, who weighs 217 pounds, and is 6 feet 5 inches tall. The parents for three generations have been normal, and average 5 feet 8 inches in height.

J. T. GRAY, M.D., Stillwater, Okla.

ANSWER.—The following is a list of references concerning disease of the pituitary gland:

Cushing, Harvey W.: Pituitary Body and Its Disorders, Philadelphia, J. B. Lippincott Company, 1912, $4.

Pfister, F.: Two Cases with Tumors Originating from Region of Hypophysis, *Wisconsin Med. Jour.*, May 1913.

Grinker, J.: Tumor of Hypophysis in Case of Acromegaly, THE JOURNAL, July 26, 1913, p. 235.

Luger, A.: Some Features of Roentgenographic Changes in Pituitary Diseases, THE JOURNAL, Sept. 6, 1913, p. 752.

Lewis, D. D., and Miller, J. L.: Relation of Hypophysis to Growth and Effect of Feeding Anterior and Posterior Lobe, *Arch. Int. Med.*, August, 1913; abstr., THE JOURNAL, Sept. 13, 1913, p. 896.

Barnabo, V.: Relations Between Hypophysis and Ovaries or Testicles, *Policlinico* (Surgical), August, 1913.

Frazier, C. H. and Lloyd, J. H.: A Case of Tumor of Hypophysis, Partially Removed by Transfrontal Method of Approach, THE JOURNAL, Nov. 1, 1913, p. 1626.

Taylor, A. L.: Case of Tumor of Pituitary Body, *Lancet*, London, Nov. 22, 1913.

Mamrot, A.: Hypophysis Tumor Syndrome in Young Man, *Arch. de méd. d. enf.*, December, 1913.

Lunghetti, B.: Tumor in Hypophysis Region, *Tumori*, February, 1914.

Finch, L. H.: Tumor of Hypophysis Cerebri, *New York State Jour. Med.*, March, 1914.

Gilmour, A.: Hypertrophic Pulmonary Osteo-Arthropathy (Marie's Disease), *Edinburgh Med. Jour.*, June, 1914.

Johnson, W.: Pathologic Investigation of Four Cases of Pituitary Tumor, *Lancet*, London, July 4, 1914.

Eltester: Acromegaly Plus Splanchnomegaly with Hypophysis Tumor in Male Cadaver of 32, *Med. Klin.*, Aug. 2, 1914.

Viscontini, C.: Infantilism, Fat Deposits and Genital Dystrophy with Tumor of Hypophysis, *Gazz. d. Osp.*, July 26, 1914; abstr., THE JOURNAL, Sept. 5, 1914, p. 898.

Bergeim, O.; Stewart, F. T., and Hawk, P. B.: Metabolism of Calcium, Magnesium, Sulphur, Phosphorus and Nitrogen in Acromegaly, *Jour. Exper. Med.*, September, 1914; abstr., THE JOURNAL, Sept. 26, 1914, p. 1135.

Halsted, T. H.: Intranasal Operation in Tumor of Hypophysis, *New York Med. Jour.*, Oct. 31, 1914.

Williams, T. A.: Case of Pituitary Disease Showing Both Acromegaly and Adiposis, *Washington Med. Ann.*, March, 1915.

DENTAL CLINICS

To the Editor:—In the *Washington Medical Annals*, January, 1915, there was published an article on school clinics, which I wrote, based on information gathered by the U. S. Bureau of Education. This article contains the names of all communities having school clinics, and shows that at the time when the statistics were gathered (up to October, 1914) forty-six communities had clinics for treating the teeth of schoolchildren; since that time Pittsburgh has also established school clinics for the eyes and teeth. This is in reply to the inquiry of R. B. (THE JOURNAL, May 22, 1915, p. 1782).

GEORGE H. HEITMULLER, M.D., Washington, D. C.

Medical Education and State Boards of Registration

COMING EXAMINATIONS

ALABAMA: Montgomery, July 6. Chairman, Dr. W. H. Sanders, Montgomery.

ALASKA: Juneau, July 6. Sec., Dr. Harry C. DeVighne, Juneau.

ARIZONA: Phoenix, July 6-7. Sec., Dr. John Wix Thomas, Phoenix.

COLORADO: Denver, July 6. Sec., Dr. David A. Strickler, 612 Empire Bldg., Denver.

CONNECTICUT: New Haven, July 13. Sec., Dr. Charles A. Tuttle, 196 York St., New Haven; Eclectic: New Haven, July 13. Sec., Dr. T. S. Hodge, 19 Main St., Torrington; Homeopathic: New Haven, July 13. Sec., Dr. Edwin C. M. Hall, 82 Grand Ave., New Haven.

DISTRICT OF COLUMBIA: Washington, July 13. Sec., Dr. Edgar P. Copeland, The Rockingham, Washington.

INDIANA: Indianapolis, July 13-15. Sec., Dr. W. T. Gott, 120 State House, Indianapolis.

MAINE: Augusta, July 6-7. Sec., Dr. Frank W. Searle, 776 Congress St., Portland.

MASSACHUSETTS: Boston, July 13-15. Sec., Dr. Walter P. Bowers, Room 501, No. 1 Beacon St., Boston.

NEW HAMPSHIRE: Concord, July 6-7. Regent, Mr. H. C. Morrison, Concord.

NEW MEXICO: Santa Fe, July 12. Sec., Dr. W. E. Kaser, East Las Vegas.

NEW YORK: Albany, Buffalo, New York and Syracuse, June 29-July 2. Mr. Harlan H. Horner, Chief, Examination Division, State Education Bldg., Albany.

NORTH DAKOTA: Grand Forks, July 6-9. Sec., Dr. G. M. Williamson, Grand Forks.

OKLAHOMA: Oklahoma City, July 13. Sec., Dr. Ralph B. Smith, 502 Daniel Bldg., Tulsa.

OREGON: Portland, July 5. Sec., Dr. L. H. Hamilton, Medical Bldg., Portland.

RHODE ISLAND: Providence, July 1. Sec., Dr. Gardner T. Swarts, State House, Providence.

SOUTH DAKOTA: Pierre, July 12. Sec., Dr. Park B. Jenkins, Waubay.

UTAH: Salt Lake City, July 5. Sec., Dr. G. F. Harding, 407 Templeton Bldg., Salt Lake City.

VERMONT: Burlington, July 1-3. Sec., Dr. W. Scott Nay, Underhill.

WASHINGTON: Seattle, July 6. Sec., Dr. G. N. Suttner, Baker Bldg., Walla Walla.

WISCONSIN: Milwaukee, June 29-July 1. Sec., Dr. J. M. Beffel, 3200 Clybourn St., Milwaukee.

WYOMING: Laramie, June 28-30. Sec., Dr. H. E. McCollum, Laramie.

Missouri March Report

Dr. J. A. B. Adcock, secretary of the Missouri State Board of Health, reports the oral and written examination held at St. Louis, March 22-24, 1915. The total number of subjects examined in was 14; total number of questions asked, 100; percentage required to pass, 75. The total number of candidates examined was 26, of whom 20 passed and 6 failed. Five candidates were granted reregistration licenses. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
University of Arkansas		(1913)	84.2
Bennett Medical College		(1914)	85.6
College of Physicians and Surgeons, Chicago		(1893)	75
Rush Medical College		(1913) 90.7; (1914)	87.5, 85.2
Tufts College Medical School		(1905)	80.2
American Medical College		(1914)	77.9, 82.4, 90
St. Louis College of Phys. and Surgs.		(1908) 77.5; (1914)	75.8, 76.6
Washington University		(1904)	83.7
University and Bellevue Hospital Medical College		(1914)	88.8
Meharry Medical College		(1904)	75
University of West Tennessee		(1914)	76, 78.9, 82.1
Fort Worth School of Medicine		(1906)	75
	FAILED		
American Medical College		(1914)	72.3
St. Louis College of Phys. and Surgs.		(1910) 69.1; (1914)	71.5
University of West Tennessee		(1914)	70.8, 73.2, 73.5

Colorado April Report

Dr. David A. Strickler, secretary of the Colorado State Board of Medical Examiners, reports the oral and written examination held at Denver, April 6, 1915. The total number of subjects examined in was 8; total number of questions asked, 80; percentage required to pass, 75. The total number of candidates examined was 4, of whom 3 passed, including 1 osteopath, and 1 failed. Eleven candidates were licensed through reciprocity. One candidate was granted a reregistration license. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
University of Louisville		(1914)	88.1
John A. Creighton Medical College		(1914)	81.6
	FAILED		
Tokyo Charity Hosp. College, Japan*		(1911)	58.5

* Not included in the official list of foreign medical colleges prepared by the Council on Medical Education.

College	LICENSED THROUGH RECIPROCITY	Year Grad.	Reciprocity with
College of Phys. and Surgs., Chicago		(1907)	Illinois
Northwestern University		(1912)	Illinois
Indiana University		(1913)	Indiana
Medical College of Indiana		(1901)	Indiana
University of Louisville		(1912)	Tennessee
University of Maryland		(1902)	Maryland
Harvard Medical College		(1898)	Mass.
Northwestern Medical College of St. Joseph		(1890)	Missouri
New York Homeopathic Medical College		(1881)	Missouri
Meharry Medical College		(1904)	Oklahoma
Memphis Hospital Medical College		(1898)	Mississippi

Idaho April Report

Dr. Charles A. Dettman, secretary of the Idaho State Board of Medical Examiners, reports the written examination held at Lewiston, April 6-7, 1915. The total number of subjects examined in was 11; total number of questions asked, 110; percentage required to pass, 75. The total number of candidates examined was 17, of whom 16 passed and 1 failed. One candidate was licensed through reciprocity. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
University of Colorado		(1914)	83
College of Physicians and Surgeons, Chicago		(1912)	86
Illinois Medical College		(1905)	84
Rush Medical College		(1912)	87
University of Illinois		(1913)	80
Indiana University		(1909)	83
State University of Iowa, College of Medicine		(1897)	84
Southern Homeopathic Medical College		(1904)	79
St. Louis University		(1906)	75
Jefferson Medical College		(1896) 90; (1912)	87
Medico-Chirurgical College of Philadelphia		(1906)	81
College of Physicians and Surgeons, Memphis		(1910)	82
University of Vermont		(1908) 80; (1914)	84
Marquette University		(1913)	78
	FAILED		
University of the South		(1909)	70

College	LICENSED THROUGH RECIPROCITY	Year Grad.	Reciprocity with
Denver and Gross College of Medicine		(1908)	Utah

Minnesota April Report

Dr. Thomas S. McDavitt, secretary of the Minnesota State Board of Medical Examiners, reports the oral, practical and written examination held at Minneapolis, April 6-8, 1915. The total number of subjects examined in was 8; total number of questions asked, 80; percentage required to pass, 75. The total number of candidates examined was 7, of whom 6 passed and 1 failed. Twelve candidates were licensed through reciprocity. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
Rush Medical College		(1914)	87
Johns Hopkins University		(1914)	90
Boston University		(1909)	80
University of Minnesota		(1909)	88
Cornell University		(1913)	85
University of St. Joseph, Beirut		(1914)	82
	FAILED		
Hamline University		(1904)	69

College	LICENSED THROUGH RECIPROCITY	Year Grad.	Reciprocity with
Coll. of Phys. and Surgs., Chicago		(1907) S. Dakota; (1909)	Illinois
Hahnemann Med. Coll. and Hosp., Chicago		(1908)	Illinois
Rush Medical College		(1908)	Illinois
Indiana Medical College		(1906)	Indiana
State Univ. of Iowa, Coll. of Homeo. Med.		(1908)	Iowa
University of Louisville		(1911)	N. Dakota
Hamline University		(1907)	N. Dakota
John A. Creighton Medical College		(1913)	Nebraska
Marquette University		(1914, 2)	Wisconsin
University of Toronto		(1906)	N. Dakota

Nevada May Report

Dr. S. L. Lee, secretary of the Nevada Board of Medical Examiners, reports the written examination held at Carson City, May 3-5, 1915. The total number of subjects examined in was 13; total number of questions asked, 100; percentage required to pass, 75. The total number of candidates examined was 7, all of whom passed, including 1 osteopath. Five candidates were licensed through reciprocity. The following colleges were represented:

College	PASSED	Year Grad.	Per Cent.
California Eclectic Medical College	(1913) 87.7;	(1914)	83.3
Coll. of Phys. and Surgs., San Francisco.	(1911) 77.3;	(1914)	80.1
Tulane University of Louisiana		(1914)	95.3
Medico-Chirurgical College of Philadelphia		(1912)	86.4

College	LICENSED THROUGH RECIPROCITY	Year Grad.	Reciprocity with
Chicago College of Medicine and Surgery		(1913)	Nebraska
State University of Iowa College of Medicine		(1911)	Iowa
University of Michigan, Dept. of Med. and Surg.		(1903)	N. Carolina
St. Louis University		(1913)	Missouri
Omaha Medical College		(1896)	Nebraska

Book Notices

DIRECTIONS FOR A PRACTICAL COURSE IN CHEMICAL PHYSIOLOGY. By W. Cramer, Ph.D., D.Sc. Second Edition. Paper. Price, $1 net. Pp. 102. New York: Longmans, Green & Co., 1915.

This is one of the best guides for a general course in chemical physiology which we have seen. It is intended for the use of the medical student, and has just enough material to enable the worker to grasp the fundamental facts of physiologic chemistry, which are of such importance in the proper understanding of the clinical phenomena. The subject-matter is divided into three parts. Part I deals with animal and vegetable tissues and fluids; Part II treats of digestion, and Part III covers, in a general way, normal and pathologic metabolism. No attempt is made to present the subject in an exhaustive way, as this is necessary only for the specialist, for whom the book is not intended. The text, which is limited to experiments and deductions from these experiments, is presented in a clear and instructive manner. This work is recommended both to the teacher who may wish a brief and practical guide for his students, and to the worker who may desire to familiarize himself with the basic principles of chemical physiology.

PYELOGRAPHY (PYELO-URETEROGRAPHY). A Study of the Normal and Pathologic Anatomy of the Renal Pelvis and Ureter. By William F. Braasch, M.D. Cloth. Price, $5 net. Pp. 323, with 296 illustrations. Philadelphia: W. B. Saunders Company, 1915.

This is the first systematic presentation in any language of a method of diagnosis of kidney and ureteral affections, to which Voelker first called attention ten years ago. The author deplores the unjust condemnation of the method because of the deaths following its employment in a few cases. The majority of these ill effects were due to the use of too much force in injecting the solutions into the upper urinary tract. The book is based on the experience of the author in 2,000 cases, and the absence of any complication in this large number of pyelograms is the strongest argument for the gravity method which he employs. The numerous excellent roentgenograms show that pyelography is an almost indispensable diagnostic aid in renal and ureteral lesions. A careful study of the book is recommended to those interested in urologic as well as in general abdominal conditions.

EVOLUTION AND DISEASE. By J. T. C. Nash, Captain, R. A. M. C., T. F., S. S. Cloth. Price, $1.40 net. Pp. 73. New York: William Wood & Co., 1915.

This book consists of the Chadwick Public Lectures for 1913. The author traces in simple language the growth of our modern knowledge regarding the spread of disease, and shows the remedy in public education.

Society Proceedings

COMING MEETINGS

AMERICAN MEDICAL ASSOCIATION, San Francisco, June 21-25.

American Ophthalmological Society, New London, Conn., July 6-7.
Montana State Medical Association, Bozeman, July 14-15.
Washington State Medical Association, Tacoma, July 20-22.

MISSOURI STATE MEDICAL ASSOCIATION

Fifty-Eighth Annual Meeting, held at St. Joseph, May 10-12, 1915

The President, DR. H. C. SHUTTEE, in the Chair

Pneumonia Treated with Rosenow and Hektoen's Antigen

DR. OLA PUTMAN, Marceline: Sixteen patients received the treatment without a fatality. The average time of crisis from the onset was four and one-quarter days.

DISCUSSION

DR. C. L. WOOLSEY, St. Joseph: I recently treated a patient, aged 62, who had developed the disease two days before he called for the doctor. His symptoms, therefore, were quite grave, including a bad mitral lesion. I gave him sensitized pneumococci, four injections, the last two containing 500 million germs. He made a speedy recovery.

Essential Hemorrhage from the Uterus

DR. C. H. WALLACE, St. Joseph: In essential hemorrhage from the uterus, the flow may occur without physical signs and symptoms, except the bleeding. This flow is never intramenstrual, generally is most excessive at the menstrual epoch, and may run from one period into another. The uterus may be slightly larger than normal, but perfectly mobile and with no other physical signs of disease. It occurs in the young or middle aged. The condition seems to be allied to uterine fibrosis. The hemorrhage may extend over a period of several years, the patient's general health being impaired from loss of blood.

DISCUSSION

DR. CARYL POTTER, St. Joseph: I do not believe in the conception of essential hemorrhage. There are several constitutional causes of hemorrhage. I should hesitate long before performing hysterectomy on a patient under 35 or before the menopause.

DR. JOHN J. SHELDON, Kansas City: Hysterectomy may be the only means of relief, but it is a great injury to the patient if done unnecessarily. The number of cases, however, demanding this extreme measure is exceedingly small.

DR. C. H. WALLACE, St. Joseph: In all my cases the ovary was left. Hysterectomy should be resorted to only after every other measure of relief has failed.

Renal Tuberculosis

DR. JAMES P. HENDERSON, Kansas City: Postmortem statistics show that from 50 to 60 per cent. of the cases are bilateral. It is of great importance to know whether one or both kidneys are involved and with what degree of destruction. Early tuberculosis affects but one kidney in from 90 to 95 per cent. of cases. It is my opinion that in cases of uremic anuria or acute suppression following surgical operation on one kidney, the other is found tuberculous in from 25 to 30 per cent., and that the destruction of the kidney is either primary or secondary in 95 per cent. of cases, and is secondary to tuberculosis elsewhere in the body. Tuberculosis of the bladder and ureter occurs in from 10 to 20 per cent., and is always secondary. In the acute miliary type there is no symptom to make the physician suspect the tuberculosis, all symptoms pointing to the systemic affection. In the caseating form there may be only constitutional symptoms, no local ones.

DISCUSSION

DR. E. G. MARK, Kansas City: No urine should be taken for diagnosis or accepted for that purpose except urine withdrawn by the catheter.

DR. J. I. BYRNE, St. Joseph: If persistent irritability of the bladder, frequent diurnal and nocturnal urination which does not respond to treatment, general systemic decline, blood pressure below normal, pus or blood in the urine, exists, you have reason to suspect renal tuberculosis.

DR. J. P. HENDERSON, Kansas City: The majority of general practitioners can make the diagnosis without difficulty, but they fail in the treatment. Too often the bladder is held responsible, and treatment is given for a long period until the patient is completely "washed out."

DR. C. R. BURFORD, St. Louis: Every general practitioner should be able to diagnose renal tuberculosis. There are two points to bear in mind: First, never examine voided urine for tubercle bacilli. Second, the initial complaint of the patient generally is of bladder irritability and lessened capacity of the bladder.

Unilateral Renal Hematuria

DR. C. M. NICHOLSON, St. Louis, gave a description of the causes, varieties and pathology of renal hematuria with report of cases and the results of treatment.

DISCUSSION

DR. W. J. FRICK, Kansas City: With the various methods at our command, I believe we can usually make out the cause of this condition. The cystoscope is probably the most important of all the diagnostic methods we have, as it will show which kidney is bleeding and at the time tell us the condition of the other kidney. Next in importance is the Roentgen ray, by which we can ascertain whether the cause of the bleeding is a stone, which is the common cause for renal hemorrhage, or whether there is a tumor present, and sometimes we can obtain an idea of what kind of tumor it is if present. In tuberculosis of the kidney, the Roentgen ray may show caseation. Other methods are the microscopic examination of the urine and ureteral examination. Many cases present no symptoms except the hemorrhage, and these make up the so-called cases of essential hematuria, the diagnosis of which is made only by exploratory operation.

DR. L. T. DUNAWAY, Eldorado Springs: I had a case of renal hematuria with which I worked for eighteen months. Finally I put the patient on nitric acid, 3 drops, three times a day, and in about four weeks she was well. Another woman had suffered for fourteen months, and was weak and anemic. Then she saw a boy fall from a table and was severely shocked. From that day on the hemorrhage ceased.

DR. L. F. BODY, St. Joseph: About twelve years ago, Steinwerk first discovered that renal hematuria was sometimes due to varix in the veins and papillae of the kidney. He curetted the bleeding points, and this was followed by relief of the condition. Others have made similar cures. Renal varix, however, is not the only cause of the trouble. Other pathologic conditions give rise to hemorrhage.

DR. JACOB GEIGER, St. Joseph: In the last few weeks I have operated in three cases which had been treated medically by competent physicians. I exposed the kidneys, but careful examination failed to disclose any pathologic condition. After splitting the kidneys and suturing with catgut, I replaced the organs, and all the patients are apparently well.

DR. E. G. MARK, Kansas City: I have wondered whether the angioneurotic kidney is not responsible for the so-called essential hematuria. To have hemorrhage you must have some pathologic condition; yet we are sometimes confronted by cases in which we operate when no pathologic condition was found beforehand and no abnormal condition discovered later in the laboratory. The operation of splitting the kidney is unquestionably beneficial.

DR. J. E. DEWEY, Springfield: A man of 56 had been suffering from hematuria for three years. I was unable to find anything the matter with the kidney, so I removed it. Later searching showed a small concretion in one of the papillae which it would have been impossible for the man in his anemic condition to throw off. The second case was in a young man, an epileptic, who had been bleeding for fifteen months. We could find no lesion, either before or after nephrectomy. Perhaps these cases would come under the head of angioneurotic kidney.

DR. C. M. NICHOLSON, St. Louis: Since in the majority of cases the symptom, whether or not we know the pathologic condition, is what we are treating, if it can be overcome by simply bisecting the kidney, this is better than to perform nephrectomy.

Factors of Safety in Goiter Operations

DR. VILRAY P. BLAIR, St. Louis: Refraining from radical operation during the height of crises, in the presence of grave degeneration, or functional disturbances of vital organs, is the most important working rule. A more potent factor, but rarely within the surgeon's control, would be to do necessary radical operations at an earlier period of the disease, before goiters reach the intensely toxic stage, before they cause degenerative changes in vital organs, and before they have become fixed in positions that render their removal excessively difficult and dangerous. Except in the presence of imminently grave obstruction, patients with simple goiters who are in poor condition should be nursed along until they are acceptable risks before thyroidectomy is undertaken. Preliminary ligation of thyroid vessels is ordinarily the most effective way of reducing the toxicity of exophthalmic goiters, and the postoperative behavior of the patient serves as a reliable indication as to how well a thyroidectomy would be tolerated. The avoidance of antiseptics and general anesthetics also reduces the liability of postoperative intoxication. Preservation of the integrity of important structures, the recurrent laryngeal nerves, parathyroids, the trachea and pharynx, is best assured by careful hemostasis during operation, the extraglandular ligation of the thyroid arteries and the preservation of the posterior capsule of the gland.

DISCUSSION

DR. W. T. COUGHLIN, St. Louis: We do not have the selection of cases in our hands. Usually the patient is sent to us with the expectation that we will operate. If the profession were educated to the point where patients would be sent to the surgeon as soon as response to medical treatment fails, the surgeon's work in selected cases would be greatly simplified. If the goiter has developed very rapidly, it is just as well to let it alone. The most dangerous cases are the rapidly growing exophthalmic type. If the patient fails to benefit by rest in bed, surgery should not be undertaken.

DR. V. P. BLAIR, St. Louis: There is one class of exophthalmic goiter which comes to the surgeon in which he will avoid operation if he regards the individual's good, unless forced to take the risk, that is, the goiter which has gradually led up to crisis, which has existed for a long time and shows evidence of degeneration, especially if mental symptoms are developing. Very interesting at present is the question of operating in those cases in which there is a suspicion of involvement of other ductless glands. Our present position is that, given a case of exophthalmic goiter, regardless of what other ductless glands may be involved, the removal of thyroid tissue will help the patient.

DR. ROLAND HILL, St. Louis: One point which ought to be emphasized is that goiters giving rise to nervous symptoms, especially in women over 25, should be seen by the surgeon before marked degeneration occurs.

Gastro-Enterostomy

DR. HERMAN E. PEARSE, Kansas City: The average length of time that patients endure dyspepsia and various stomach symptoms due to gastric and duodenal ulcer before coming to the surgeon for cure by gastro-enterostomy is fifteen years. The symptoms that bring patients to successful operative cure are pain, loss of weight, vomiting and hemorrhage.

DISCUSSION

DR. WILLARD BARTLETT, St. Louis: We do not operate for ulcer. We do not know what causes an ulcer, nor does any surgical operation cure the operation per se, an ulcer always being a secondary condition. We operate for certain complications of ulcer, and obstruction is the one which most

commonly brings the patient to operation. Perforation practically always demands immediate operation; we operate for small repeated hemorrhages which gradually deplete the patient; we operate for cancer on an ulcer basis and for "medical failures," although not using that term in any sense as a criticism, because from the very nature of the facts, many medical treatments are bound to fail. I do not believe that more than two fifths of all ulcers are surgical; three fifths are greatly benefited if not actually cured by such methods as are used by Sippy and others. Five forms of operation are applicable to ulcer, according to the case. Certain operators resect the ulcer-bearing area. Certain others resort to blocking the stomach at some point so that food cannot go over the ulcer area, and a drainage operation is done. Then there is excision of the ulcer, the fourth method, pyloroplasty, which is seldom used, and the fifth method, gastro-enterostomy, which is by far the most frequently used and the most useful of all operations for this condition.

A Question in Dealing with Abdominal Adhesions

DR. FRANK G. NIFONG, Columbia: The formation of abdominal adhesions is one of Nature's methods of limiting the extension of the infection. The observation of adhesions in animals indicates that Nature provides those most exposed to infection by habits and environment with the greatest ability to form adhesions. Resistance to peritoneal infection seems to be in direct proportion to the animals's power to form adhesions. The kind of infection producing the inflammation has something to do with the readiness by which adhesions are formed. Late postoperative shock, so-called "secondary shock" is not truly shock, but is due to the overwhelming of the nerve centers by the sudden turning loose of a large dose of protein poison. Theory is not incompatible with Crile's kinetic theory, but the application of the principles of anoci-association is impracticable. Breaking down old adhesions, breastworks in the presence of leukocytosis, or active battle in war analogy, would seem to be treasonable. What is needed from a surgical standpoint is some index to the patient's resistance and the amount of operative procedure permissible.

DISCUSSION

DR. H. E. PEARSE, Kansas City: The presence of the retained shock is correctly attributed by Dr. Nifong to the blow of extensive internal dissection. But when the heart is struggling under a load of infection, it seems to me a poor plan to add 30 or 40 ounces to the circulation by intravenous transfusion. It is desirable to dilute the blood and dilute the toxemia. I have seen two patients die very promptly from this method of treatment. The water should be placed under the skin where Nature can make use of it if she wants to take it up, but it should not be put into the circulation. The one thing that has pulled these patients through for me whenever everything else failed is atropin.

DR. W. T. COUGHLIN, St. Louis: I believe that delayed shock always indicates latent hemorrhage. The patient who dies from shock never reacts after the primary operation. Epinephrin is a very dangerous drug and should be used, if used at all, with extreme caution.

Tumors of the Carotid Body

DR. C. W. RUSSELL, Springfield, cited a case of ten years' standing, with a brief review of the anatomy, physiology and embryologic features so far as they have been investigated.

DISCUSSION

DR. J. F. BINNIE, Kansas City: About twenty years ago I operated for a tumor that I had diagnosed lymphangioma on the right side of the neck. In the course of the operation I changed my mind, and told the students present that I thought it was one of those cases then recently described in English literature as a potatolike tumor of the neck which had crystallized into tumors of the carotid. If I remember rightly, I dissected the tumor out without ligating the carotid vessels. The diagnosis of tumor of the carotid body was confirmed by Dr. Frank Hall. The subsequent history of the case was lost in the chaos which surrounded all city hospital records in Kansas City at that time.

DR. C. W. RUSSELL, Springfield: About two years following the removal of the tumor, there appeared on the opposite side of the neck a small, freely movable tumor, which was properly located and which I removed. It proved to be a hypertrophy of one of the lymph nodes.

ASSOCIATION OF AMERICAN PHYSICIANS

Thirtieth Annual Meeting, held at Washington, D. C., May 11-13, 1915

(Continued from page 2091)

A Method of Determining Total Plasma and Blood Volume

DRS. L. G. ROWNTREE, N. KEITH, and J. T. GERAGHTY, Baltimore: The method consists of injecting into a vein a given quantity of nontoxic, nondialysable red dye; in three and six minutes, specimens of blood are taken and the degree of dilution of the dye determined. A standard solution is prepared by securing some blood before the dye is injected, and diluting an amount of dye equal to the dose to 4 per cent. of the body weight, using for the diluent 1 part serum and 3 parts salt solution. When the blood is taken after the injection of the dye, the serum is separated, diluted and compared with the standard solution: from this point the calculation is easy. The loss of the dye from the human circulation has been found to be only from 1 to 2 per cent. The dye cannot be found in the tissues, and it is not believed that it goes into the blood cells, either red or white. The average figures in normal individuals indicate that the blood volume should be 85 c.c. per kilogram, or about one twelfth the body weight. In essential hypertension and in diabetes, the blood volume has been found to be normal. In pregnancy there is a large increase in the blood mass which does not disappear until from seven to ten days after delivery. This would seem to be a physiologic preparation for hemorrhage.

Simple Method of Determining Variations in the H Ion Concentration in the Blood

DRS. L. G. ROWNTREE, MCKIM MARRIOTT and R. L. LEVY, Baltimore: The method consists of adding an indicator (phenolsulphonephthalein) to the dialysate of blood serum and comparing with a solution of known H ion concentration. The normal figures for H ion concentration are from 7.6 to 7.8. Many cases have been studied, among them twenty cases of acidosis, all of which have shown a concentration toward the acid side, as low as 7.0. In experimental acidosis, the readings went as low as 6.7, at which point the animals died. In alkalosis, the readings may go up to 8.0 or 8.1, when the animal dies. By this method the buffer values of the blood may be determined, and in acidosis the buffer values are very low. It is an easy method to study both acidosis and alkalosis from the blood side.

Case of Severe Anemia with Leg Ulcer and Remarkable Blood Findings

DRS. JEROME E. COOK, JEROME MEYER and GEORGE DOCK, St. Louis: The case is one of severe anemia occurring in a young mulatto girl. There is a complication of recurring, indolent, leg ulcers. The red cells show the greatest degree of variation both in size and shape, giving the appearance as if many of the cells had been broken into fragments; but the most frequent abnormal type is a much elongated, curled red cell often more or less sickle shaped. Among the white cells an eosinophilia of varying and sometimes intense degree is the most marked feature. The other children in the family (two), are dead; both suffered from severe anemia. Two similar cases are recorded in the literature; both cases were in mulattos and both had a chronic type of leg ulcer.

Unusual Condition of the Blood in Primary Pernicious Anemia

DR. N. E. BRILL, New York: A woman, aged 43, mother of five children, nonsyphilitic, presented all the classical signs

of a primary pernicious anemia, which began one year ago, insidiously, with gradually increasing sense of fatigue and later weakness with disturbed gastric symptoms, as vomiting for three weeks, and eructations of gas. Six weeks before coming under observation, weakness became extreme, and the skin pale and light yellow; visual power markedly diminished; cardiac palpitation, tinnitus aurium and vertigo were complained of; there had been no bleeding from the mucous membranes or into the skin. Six pounds were lost in weight during the year. Physical examination revealed a yellow skin, a slightly enlarged liver, a relatively larger spleen which could be felt over 3 c.c. below the costal border; tender tibiae and sternum, and a blood picture of high color-index (1.5) and the associated conditions of the cells indicating the presence of an anemia gravis. A transfusion of blood was done, followed in thirty-six hours by a splenectomy; following this an absence of the usual bone-marrow reaction was noted, though there was a gradual physical improvement in the patient, to the extent that she could walk again without the distress which had previously existed. In five weeks after her discharge from the hospital, there was a furibund recurrence in her symptoms which brought her back to the hospital in a worse condition than at any previous time. The blood then showed a tremendous loss of red cells, an increased activation of the leukoblastic and the erythroblastic tissues of the bone marrow, the circulating blood containing early myelocytic forms of cells, "myeloblasts or myelogones," of which a large number were phagocytic, containing one or more red cells in their cytoplasm, and a myelocytosis of 21 per cent., all accompanied by a hemoglobinemia and hemoglobinuria with the final blood picture of an acute myeloid leukanemia (von Leube) immediately before death. No necropsy could be obtained. The question arises, What relationship, if any, had the splenectomy on this unusual activation of the bone marrow?

Metabolism Studies Before and After Splenectomy in Congenital Hemolytic Jaundice

DRS. SAMUEL GOLDSCHMIDT, O. H. PERRY PEPPER and R. M. PEARCE, Philadelphia: The patient had had a severe anemia from birth with the later usual history. Metabolism studies were made both before and after splenectomy. The blood picture after operation showed marked improvement. In general, the studies indicated a tendency to lose nitrogen before splenectomy and to retain nitrogen afterward; the operation seemed to restore the capacity for nitrogen utilization. There was a high elimination of uric acid before splenectomy, with a drop of 47 per cent. in uric acid output after the operation. The iron elimination before splenectomy was 50 per cent. above the intake; after operation the iron elimination was greatly reduced. There was also a reduction of 90 per cent. in the urobilin elimination in the feces. These figures seem to support the evidence of the real benefit of the operation. Removal of the spleen seems to remove the toxic agent or the source of it, and in addition the hemolytic agent is removed as well.

Plasmaphaeresis

DRS. J. J. ABEL, B. B. TURNER, E. K. MARSHALL, JR., and P. D. LAMSON, Baltimore: Among the many points of view from which one may study the minute structures of the blood, the relation of cells to plasma led to experiments which consist of the removal of the plasma of withdrawn blood and the return of the cells to the circulation, a process to which has been given the name plasmaphaeresis. The method is as follows: An animal is bled very freely, almost to fatal exsanguination, the blood caught in a solution of herudin to prevent coagulation, diluted to double its volume with Locke's solution, centrifugalized and the supernatant plasma discarded. The cells are now diluted to the original bulk of blood with Locke's solution, and restored to the circulation of the animal. This may be done repeatedly from time to time without injury to the animal. Blood pressure estimations showed that the low pressure of the exsanguinated state was well restored on the return of the fluid to the vessels. It was also found that leech extract is not toxic, at least to the extent in which we use it. But since the war, the supply of leeches has been interrupted and a manufactured herudin has been tried; this product is very toxic, quantities as small as 10 mg. being sufficient to kill animals with symptoms of great shock.

Preservation in Vitro of Living Erythrocytes

DRS. PEYTON ROUS and J. R. TURNER, New York: There are several practical purposes involved in attempts to preserve intact mammalian red blood cells: for culture materials in the cultivation of plasmodia; for readily available indirect transfusion material, etc. Washed cells were first used, but were found to disintegrate very early. The addition of citrated plasma prevents this injury. Gelatin, in the proportion of 0.125 per cent. in Ringer's or salt solution will also protect the cells for a long time. Cells were tested by shaking to compare their fragility when thus treated with their fragility to hypotonic salt solution: there was no relation between the degrees of fragility, though bloods differ in their behavior in this regard. Human blood cells can be washed without injury. Cells are protected but not preserved by gelatin; the addition of glucose or saccharose, however, to gelatin Ringer's solution will preserve the cells for a long time. Cells that have been kept several weeks take up and surrender oxygen normally, do not clump or show morphologic change, and behave normally in the Wassermann reaction. Rabbits were exsanguinated, and preserved blood used to supplant that withdrawn; the animals were fully restored and behaved normally after the operation. Many tests corroborated this experience. Rabbit blood can be kept alive at least two weeks. Human blood can be kept for several weeks in dextrose-gelatin solution. Effete blood cells when introduced into the circulation can take up and give off hemoglobin, but they quickly disappear from the circulation; but when the animals are treated by the introduction of blood preserved in the manner described, no changes can be found afterward, even in the spleen.

Clinical Studies in Blood Transfusion

DRS. E. LIBMAN and R. OTTENBERG, New York: In simple hemorrhage, the results of transfusion were uniformly good, especially in hemorrhage of gastric and duodenal ulcer. Transfusions made during the progress of the hemorrhage acted equally well as when made after the accident, and seemed to encourage spontaneous arrest of the effusion. In six cases of dysentery, transfusion was followed by marked improvement. In seven cases of typhoid hemorrhage, nine transfusions were done with two recoveries. Transfusion is useful in operative work, both before and after operation; but it is of no help in surgical shock. In purpura hemorrhagica, transfusion was done twelve times in nine cases; six patients recovered, the two deaths being in cases occurring shortly after pregnancy. In this disease, transfusion appears to have a direct curative value. For hemophiliacs, a donor should be picked in advance for possible needs. For prophylactic purposes, a small transfusion every few months may be useful. Transfusion is much more helpful than the injection of serum. For the treatment of postoperative hemorrhage in obstructive jaundice, transfusion was not of material benefit. The suggestion was made that in this condition there should be a preliminary bleeding with a large transfusion from several donors. In pernicious anemia and leukemia, the results were not uniformly good. In twenty-five cases of pernicious anemia, fourteen showed for a time progressive improvement; eight of these patients are alive at the present time, but they all present evidences of blood trouble. In eleven cases, transfusion was of no avail; two cases were also splenectomized without improvement. In one case, there were four transfusions, followed later by splenectomy; a remission then took place. Transfusion does more than anything else to abate the blood symptoms. It is important to try several donors when no improvement follows one or more transfusions from a single donor.

The effect of transfusion on the symptoms of pernicious anemia may be summarized thus: The appetite improves, the mental symptoms grow better, the glossitis clears up, and the blood picture improves; but the spinal cord symptoms do not improve. There is fever in 50 per cent. of the cases;

some become afebrile after transfusion. The fever may be due to toxic causes or to the anemia. In this disease, splenectomy is advisable; if no remission occurs after the operation, then transfusion should be done; or if remission does not follow transfusion, then splenectomy should be resorted to. We may thus determine the relative values of the two methods of treatment. In leukemia, there was some improvement following transfusion in a number of cases; but it was not lasting. In acute infections, transfusion has no very large field of application. Patients may be helped along by it at times, but the best results are to be had in long-continued subacute infections. In endocarditis with retention of infection, transfusion does good only to the extent of prolonging life for a time. The Unger method of direct transfusion and the Weil citrate indirect method are the best, and will supersede all others.

Discussion on Blood and Blood Diseases

DR. R. C. CABOT, Boston: In six cases of pernicious anemia, splenectomy has been done in the past four months. No marked improvement could be noted in the first two or three weeks after splenectomy; then there was a rapid rise in the cell count, more rapid than that which may be noted in a spontaneous remission or after treatment by transfusion or salvarsan. All of the cases have gone above 4,000,000 in the cell count. Four out of the six patients are now at work, whereas before the operation they were entirely helpless. The blood still shows very definite changes.

DR. JOSEPH L. MILLER, Chicago: Removal of the spleen does not remove the hemolytic agent; it seems to stimulate resistance of the cells and the bone marrow, so that the blood recovers somewhat in spite of the hemolytic agent. I recall a case in which there were progressively increasing spinal cord lesions after splenectomy, thus further indicating the retention of the hemolytic agent.

DR. R. WEIL, New York: Concerning the toxicity of sodium citrate, I used enough to keep blood fluid and in some cases to preserve such blood as long as two weeks, and then to reintroduce this blood into the circulation of animals without toxic effect. In man, 5 gm. of the citrate may be injected without producing any symptoms. The use of sodium citrate and of citrated serum has been found to have the curious effect not of increasing the coagulation time but of decreasing it. This observation may play an important rôle in the treatment of hemorrhagic diseases.

DR. THEODORE C. JANEWAY, Baltimore: My work on the arteries has shown such a lethal effect of sodium citrate on the arterial walls that it suggests caution in the use of citrated blood. Perhaps the citrate used in a transfusion is too dilute to do any harm. The results of transfusion in cases of pernicious anemia coming under my observation have been even better than those reported by Dr. Libman.

DR. J. J. ABEL, Baltimore: I have observed relaxation of the intestinal strip in citrate solution, but this is not comparable to work in vivo.

DR. R. WEIL, New York: I have injected as much as 1,400 c.c. citrated blood without producing symptoms, and I have given 5 gm. sodium citrate in water a number of times without untoward effect.

DR. PEYTON ROUS, New York: It is possible to use kept corpuscles without citrate by sedimenting and pipeting off the plasma. In using preserved blood, it must be remembered that dextrose delays clotting.

DR. W. S. THAYER, Baltimore: I have a patient who has a grave secondary anemia with a leukocytosis of 20,000. There is an increased resistance to hypotonic salt solution and a great increase of vitally staining cells.

DR. E. LIBMAN, New York: Dr. Lewis has been working with herudin and has observed the same toxicity of the manufactured article to which Dr. Abel has called attention. I would not be in favor of separating cells from plasma in transfusion work as suggested by Dr. Rous. I have seen one case in which mild diarrhea followed the transfusion of citrated blood. The symptom was trifling and its significance doubtful.

DR. N. E. BRILL, New York: Metabolism studies in my case of pernicious anemia showed no difference in iron elimination before and after splenectomy. With better protection of cells and greater production after splenectomy, it stands to reason that there should be a retention of blood. Lecithin is known to protect blood cells, but in my case there was no increase of lipoid in the blood after splenectomy.

Treatment of Tetanus by Antitoxin Given Intraspinally

DR. MATTHIAS NICOLL, JR., New York: Experiments were made to ascertain the value of intrathecal administration of antitoxin. Guinea-pigs were given twice the minimum lethal dose of tetanus toxin; they died in three days. Pigs treated thus were given antitoxin by injection into the heart cavity; they died in from five to eight days. Tetanic pigs treated by injecting antitoxin into the sciatic nerves did no better. But pigs treated by injecting one twentieth the dose of antitoxin used in the other animals into the spinal canal recovered. Several pigs were allowed to grow so tetanic that they were twisted into grotesque shapes; out of six treated by intraspinal injections of antitoxin, three recovered. Twenty human patients were treated with intrathecal injections of antitoxin, and sixteen out of the twenty recovered. The method of treatment recommended is to give from 3,000 to 5,000 units into the spinal canal, diluting the serum to from 10 to 20 c.c. to make it thin and easily diffusible; posture is not required to assist diffusion. In addition, 10,000 units should be given intravenously. The intraspinal injection should be repeated in twenty-four hours and if necessary, the intravenous injection should be repeated also. By this method, the mortality of tetanus has been reduced to 20 per cent.

(To be continued)

AMERICAN PEDIATRIC SOCIETY

Twenty-Seventh Annual Meeting, held at Lakewood, N. J., May 24-26, 1915

(Concluded from page 2094)

Allergy to Common Foods

DR. OSCAR M. SCHLOSS, New York: A number of cases of eczema and bronchial asthma prove to be due to food allergy. A satisfactory result can be obtained in some of these cases, but not in all, because there is a lack of proper substitute foods, and it is difficult to secure the reaction in all cases. The guinea-pigs used in these experiments were divided into two groups, one of which was egg fed. After thirty-five days, they were found anaphylactic. Of the others, which were fed on egg for several months, none had developed immunity. The treatment should consist either in the administration of gradually increasing amounts of the toxic protein, or in eliminating the offending protein from the diet.

DISCUSSION

DR. JOHN HOWLAND, Baltimore: These children are sensitive to so many proteins that it is hard to give them a food on which they can be nourished. The subcutaneous test is more sensitive than the cutaneous, but more difficult to interpret. This differs somewhat from anaphylactic shock, in that it is impossible to produce passive sensitization in animals or to obtain precipitins from their blood.

DR. FRITZ B. TALBOT, Boston: The longest absolute cure I have had is three years. In about 60 per cent. of a large number of cases of asthma that I have seen recently, I have found a positive skin test to some food. Egg was the most common offending article.

DR. S. MCC. HAMILL, Philadelphia: In some investigations which I have been making, I have been struck with the number of times I have obtained the reaction in children with no very definite manifestation of anaphylaxis, but with gastro-intestinal trouble accompanied with recurrent attacks of diarrhea.

DR. ROYAL S. HAYNES, New York: I have treated several cases of asthma in which the child was sensitive to egg, and in which it was also necessary to limit the amount of chicken. If the child ate a little egg or chicken, but not sufficient to develop asthma, it would get a return of eczema.

DR. ROWLAND G. FREEMAN, New York: Many children have been injured by the assumption that they have an idiosyncrasy to cow's milk. I have found none that I could not give it to, if I began with a small amount and gradually increased it to a normal quantity.

DR. ISAAC A. ABT, Chicago: While some children take care of these foods badly, others can take them without any toxic response; and the question is whether the result is due to an abnormality in the food or in the child. If in the latter, have we any means of classifying this idiosyncrasy on the part of the children?

Adaptation of an Artificial Food to Human Milk

DRS. H. J. GERSTENBERGER, H. D. HASKINS, H. H. MCGREGOR and H. O. RUH, Cleveland: There is a means of eliminating the low volatile fatty acids, for the homogenizer makes it possible to mix this fat with other constituents of the food in the form in which it exists in breast milk, and also to add any other thing that further investigation may develop, thus affording a practical method of getting much closer to securing for the great bulk of children in the cities a food which needs no dilution and can be fed to a young infant, as well as to an older one. The bacterial content is very low. The food is cheap, and will probably prove of great value to the general practitioner.

Homogenized Olive Oil-Fat-Free Milk Mixtures in Cases of Difficult Feeding

DR. MAYNARD LADD, Boston: Foreign milk usually contains a much higher percentage of fat than foods given in its place. This fact led to experimentation with other foods. By homogenizing, we are able, in cases of intolerance to cow's fat, to combine these foods with skimmed milk and produce a perfect emulsion. We can combine chemically pure casein with pure oils and pure sugars. My experiments thus far justify me in believing that in this way a food can be obtained which can be given with great improvement to the health of the patients. Olive oil combined with fat-free milk might be of great value, for olive oil costs only about a fourth as much as cream. I have had success with this method of feeding in one or two very difficult cases, but my experience has not yet been sufficient to warrant me in drawing conclusions.

DISCUSSION

DR. B. RAYMOND HOOBLER, New York: There are two types of fats: those which come from glandular tissue and those which are not glandular in type. Animals are not sufficiently or properly nourished on the latter kind of fats, but when glandular fats are added to their food, nutrition takes place. An increase in weight is not sufficient evidence of true nutrition; the animals must be able to produce normal offspring. Animals fed on nonglandular fat are unable to do this. We should inquire whether the foods suggested are capable of fulfilling this standard of nourishment.

Composition of Woman's Milk

DRS. L. EMMETT HOLT, ANGELIA COURTNEY and HELEN M. FALES, New York: After the first month there are no practical differences in the composition of the milk until the end period. The fat is highest in the transition period. In the late period, it was as high as in the mature period, except in one case. In only one case was the sugar less than 7 per cent., and in over half the cases it was over 8 per cent. It showed a diminution in quantity up to the late period. The protein did not differ much from the amount found in the early period. The milk differed but little in composition at the various ages. The total ash is practically the same in all. The ratio between the protein and the ash in human milk is practically the same as in cow's milk in the mature period, 1:5. In cow's milk, in ordinary dilutions, we are giving more mineral than the child really needs.

DISCUSSION

DR. HENRY J. GERSTENBERGER, Cleveland: What were the iron determinations?

DR. THOMAS S. SOUTHWORTH, New York: One of the interesting things is the high fat in the transition period. The bad effects of this high fat content of the mother's milk at this stage can be overcome by diluting it with some alkaline solution. The fact that the fat is normally high at this time and then begins to decrease shows that Nature comes to our aid by lowering the amount of fat.

DR. L. EMMETT HOLT, New York: The percentage of iron found by other observers is 1.7 mg. in 1,000 c.c. of milk.

Sugar in Infant Feeding

DRS. CHARLES H. DUNN, Boston, and LANGLEY PORTER, San Francisco: Eighteen patients were observed, 108 samples of urine tested, and 235 tests made. Twelve of the eighteen cases showed reducing bodies on some tests. Eight showed a loss in reducing power after shaking the picric acid. The majority were difficult feeding cases. None showed marked intolerance to any of the food elements. The effect of increased sugar on the weight of the babies was surprising. They gained rapidly at first, but less rapidly after sugar intolerance developed. It is our belief that the idea of sugar intoxication has been so exaggerated as to keep us from trying the effect of large amounts of carbohydrates for babies who show an inability to take a sufficient amount of food. Some children have been much benefited by pushing the amount of sugar temporarily above the ordinary limits.

DISCUSSION

DR. OSCAR M. SCHLOSS, New York: Some results that we obtained about a year ago did not accord with those cited. In many instances we found that the infant's urine would reduce copper, and occasionally bismuth. In a number of instances we were able to determine that the reducing substance was sugar. This sugar, however, was not lactose. It was a monosaccharid, sometimes dextrose and sometimes galactose.

DR. LANGLEY PORTER, San Francisco: There is no necessary antagonism between these findings and those in our paper; these were cases merely of disturbance, and not of intoxication. The interesting thing was the presence of reducing bodies other than sugar in such a large proportion of the urines of infants.

DR. I. A. ABT, Chicago: The idea of Finkelstein and his school is that sugar or any other food element finds its way into the circulation because there is a damaged intestinal wall. It is not damaged by the sugar or any other food, but by bacterial action or the toxic product resulting from bacterial action. Food intolerance merely means that the food breaks through the intestinal barrier.

DR. L. EMMETT HOLT, New York: What about the permanence of the gain in weight in these children? A child can have intolerance for a small amount of sugar and tolerance for a large amount. We have seen so many symptoms in children getting small amounts that we have hesitated to give a larger amount of sugar.

DR. HENRY KOPLIK, New York: There is a limitation to the amount of sugar we can administer to these children. If you persist in administering this large amount, the children gain for a while, then stand still, and finally lose.

DR. HENRY J. GERSTENBERGER, Cleveland: A high protein content will allow of a much higher percentage of sugar, and a low one most likely limits the amount.

DR. DEWITT H. SHERMAN, Buffalo: Some studies made by us seem to show that lactose stimulates motor function in the stomach more than either cane sugar or malt sugar. That, however, is probably not true, for the reason that the secretion following the ingestion of lactose was no greater than after the other two. We concluded that cane sugar stimulates the gastric secretion a little more than lactose, but that dextromaltose stimulates the secretion twice as much as lactose.

DR. J. P. CROZER GRIFFITH, Philadelphia: Last winter I tried feeding infants with foods rich in carbohydrates, and found they did very well, being able to tolerate from 10 to 13 per cent. perfectly.

DR. CHARLES H. DUNN, Boston: The problem we are studying is the possible damage produced by sugar. In this series of cases, the gain in weight was maintained, but the sugar was immediately cut down when symptoms of intolerance developed. I believe that the chief cause of those severe cases in which fat cannot be taken is prolonged overfeeding with sugar. The amount of protein given was 2.5 per cent. We found that many specimens of lactose contain gas bacillus spores and other things that tend to lead to trouble and make us draw wrong conclusions.

Indications for Treatment of Severe Diarrhea in Infancy

DRS. JOHN HOWLAND and W. MCKIM MARRIOTT, Baltimore: We tested the alveolar air in infants, and found that the carbon dioxid tension in such cases is lower than in health, especially if dyspnea is present. This low tension is an evidence of acidosis. Giving alkalies in large quantities causes the carbon dioxid tension to rise and the dyspnea to disappear. Cathartics should not be given unless there is distention of the abdomen accompanied by fever. Opium should be administered in sufficient quantity to prevent more than two or three stools a day, and alkali (preferably sodium) given, with water, in sufficient quantity and often enough to cause the dyspnea to disappear and to overcome the diarrhea. The condition is not a food intoxication, but the absence of a substance necessary to life.

DISCUSSION

DR. HENRY KOPLIK, New York: Opium is a dangerous drug in these cases, sending the children into a deeper stage of intoxication. Why attempt to stop peristalsis? Diarrhea is a means by which Nature eliminates a certain amount of poison.

DR. OSCAR M. SCHLOSS, New York: In some work which I did during the past year, I obtained results exactly comparable to those of Dr. Howland. In cases of severe intoxication and dyspnea, there was a marked lowering of the carbon dioxid in the blood.

DR. HENRY J. GERSTENBERGER, Cleveland: I should like to know the dose of alkali which Dr. Howland gives.

DR. CHARLES G. KERLEY, New York: Opium is one of the best drugs to use in intestinal diseases, but it must be used carefully. Drainage may be so excessive as to exhaust the patient.

DR. I. A. ABT, Chicago: It is important to give these children the proper kind of food to prevent acidosis, as well as to administer alkali to correct this condition.

DR. A. D. BLACKADER, Montreal: We can check peristalsis entirely with a large dose of opium, while, with a smaller one, we can check it just enough to give the digestive fluids a chance to work in the intestine. In cases of normal children, even when a cathartic is given, the stools contain much undigested food. Small doses of opium, repeated often enough to prevent this extreme waste, have never caused any disastrous results, in my experience.

DR. JULIUS P. SEDGWICK, Minneapolis: Study of the creatin-creatinin excretion in these cases of acidosis might aid in clearing up this problem.

DR. JOHN LOVETT MORSE, Boston: If there is something in the bowel that needs to come out, one should give a cathartic; but if everything doing harm is out, and the diarrhea is merely draining the tissues of water and salts, we do harm with a cathartic and good with opium. It is advisable to give alkalies before these severe symptoms develop.

DR. FRITZ B. TALBOT, Boston: In studying a large number of new-born infants, we found that the respiratory quotient was very low on the second or third day of life. It was such a low respiratory quotient as we get with acidosis or diabetes. We have not, however, found acetone bodies in the urine.

DR. JOHN HOWLAND, Baltimore: I dislike the term "acidosis," because it has been applied so loosely to a number of different diseases in which physiologic acidosis is not present. The fact that a small number of bodies of the acetone series can be found in the urine does not prove that acidosis is present. It is only when the protective mechanism of the body is called into play that we can speak of acidosis. If the infant's abdomen is distended, the intestines being full of putrefying substances, and the baby has high fever, opium should not be given. These children do not, however, come in that condition, but with a retracted abdomen, the intestines being empty. It is dangerous to let them have eight or ten large stools a day. I give a few drops of opium after each loose stool. It is surprising how much they can take without influencing their stupor in the slightest degree. We usually give 4 gm. of alkali at a time, subcutaneously, 5 or 6 gm. intravenously, and 3 or 4 gm. by mouth. I believe protein milk, rather concentrated, and in small amount, to be the best food for these patients. The appetite is almost always lost, and many infants vomit everything that is ingested.

Reducing Substance in Spinal Fluid

DRS. OSCAR M. SCHLOSS and LOUIS C. SCHROEDER, New York: The reducing substance in spinal fluid is a fermentable, dextrorotary sugar, probably dextrose. In infants free from meningeal disease, the spinal fluid sugar ranges from 0.05 to 0.134 per cent. Approximately the same figures would obtain in cases of meningismus. The spinal fluid sugar is normal. In epidemic cerebrospinal meningitis, and suppurative forms of meningitis, the sugar is greatly reduced or absent. A large proportion of the cases of tuberculous meningitis show a decrease in the sugar of the spinal fluid. An increase of sugar alone is of diagnostic importance in this disease. The reducing substance was not found decreased in cases of idiocy, cerebrospinal syphilis or anterior poliomyelitis.

DISCUSSION

DR. ALFRED HAND, JR., Philadelphia: I have examined the spinal fluid in many cases, and have found the absence of sugar in suppurative meningitis, and its presence in practically every case of tuberculous meningitis. I have come to depend on this fact in making the differential diagnosis. I believe that the ferment produced by the polymorphonuclear leukocytes causes the disappearance of the sugar in epidemic and suppurative forms of meningitis.

Meningitis in the Newborn

DR. CHARLES HERRMAN, New York: The infection may take place through the placental circulation, but this is probably rare. It may also occur, in cases of difficult labor, through premature respiration on the part of the infant, resulting in the swallowing or aspiration of contaminated amniotic fluid. Infection may likewise take place at birth, through an injury to the skull; or after birth, through the eyes, ears, nose, gastro-intestinal tract, umbilicus or genitalia. From the fact that the *Bacterium coli* is the most common causative agent in such cases, it seems probable that the infection takes place through contaminated water in the bathing tub.

DISCUSSION

DR. HENRY KOPLIK, New York: I have seen several cases of meningitis in the new-born. Babies are considered as new-born in hospitals up to the third month. Most cases are usually of streptococcic origin. One of the cases I saw was a colon meningitis; another was due to a bacillus similar to the typhoid.

DR. L. E. LAFETRA, New York: The symptoms of meningitis are not evident in these cases, the infants showing great depression or symptoms of sepsis. They do not have very high temperatures. Various organisms are found.

A Case of Amaurotic Family Idiocy in One of Twins

DR. CHARLES HERRMAN, New York: Alcohol and syphilis have been considered factors in the etiology of this disease, but it is difficult to see how any condition in the mother could affect only one of twins. These children received breast milk for only two weeks, and it could hardly be considered to be toxic for only one child. The theory of arrest of development must also be given up, because the brain of

the amaurotic infant is normal morphologically at birth and for some time afterward. Then there gradually occurs a degeneration of all the ganglion cells and loss of function. The tendency to degeneration must be born with the child and develop subsequently. Some endogenous factor comes in and affects these children, although it does not do so in one born without this weakness.

Macewen's Sign: Analysis of Anatomic Conditions which Enter Into the Production of this Sign; Its Value in Diagnosticating Changes in Intracranial Pressure

DR. HERBERT B. WILCOX, New York: A positive Macewen's sign exists when variation from the normal note is found. It consists in a relative change, rather than in a definite condition common to all diseased crania. The sign is better elicited by the stethoscope than by the unaided ear. Increased clearness of sound when percussion is made over the posterior portion of the skull, rather than near the stethoscope, is diagnostic. The sign uniformly accompanies conditions of increased intracranial tension, and is not found unless the causative factor exists. It is equally applicable to infants and to older children.

DISCUSSION

DR. L. E. LAFETRA, New York City: To me, the pitch of the sound seems of more value than its loudness. The pitch becomes higher as one approaches the bell of the stethoscope. I think the sign will prove of value in cases that are not meningitis, but meningismus, or some other type of spinal condition with increased spinal fluid.

DR. HENRY KOPLIK, New York: This is the most useful sign we have of beginning tuberculous meningitis, ordinary meningitis and serous meningitis due to otitis media. I find the greatest difficulty in applying the sign in the case of children who have had rickets. It is difficult in them to tell how much the sign is due to the slight hydrocephalus resulting from the old rickets, and how much to the new disease.

Epidemiology of Pneumonias in Children

DRS. GODFREY R. PISEK and M. C. PEASE, New York: From a study of a thousand cases, we have established a mortality rate for pneumonia of 34.3 per cent. Bronchopneumonia is preeminently a disease of the first two years of life, and is relatively uncommon after the third year. Lobar pneumonia is the type present after that period. Omitting those cases which are frankly secondary to some other condition or which occur as a terminal infection, the infection which is the etiologic factor of primary lobar pneumonia is always the pneumococcus; bronchopneumonia may be due to a number of organisms. If pneumococci are present in bronchopneumonia, they are usually one of a group of organisms, or are of low virulence. The pneumonia should be treated with a serum or vaccine derived from organisms belonging to the group causing the infection, or the therapy will be useless.

DISCUSSION

DR. JULIUS P. SEDGWICK, Minneapolis: At Minneapolis, in hospital, as well as in private practice, the mortality from lobar pneumonia in infants and young children is almost nothing.

DR. A. D. BLACKADER, Montreal: A high mortality in lobar pneumonia does not represent the experience we have in Montreal.

Unusual Case of Congenital Heart Disease

DR. JOHN LOVETT MORSE, Boston: A child of 4 years had a severe attack. No murmur could be heard by any one, however, except the house doctor. Nov. 30, 1914, he came to the hospital with the history of having been taken suddenly ill the night before. No murmurs or thrill could be heard. On the following day he was not examined, but the day after, Dr. Howland discovered a murmur, which, however, could not be heard by others. December 4, he developed a diastolic murmur, and later, a systolic murmur. This was followed by a double pneumonia. Within the next few weeks, the murmur diminished, but did not disappear. He then died suddenly, presumably from embolism. Only a partial necropsy was obtained, which showed complete atresia of the pulmonary artery, congenital defect of the intraventricular septum, vegetative endocarditis, an open ductus arteriosus, and atrophy of the right ventricle. Only five other cases like this are said to be on record.

DISCUSSION

DR. ALFRED HAND, JR., Philadelphia: In the few instances in which I have seen such a defect of the septum, the lesion has been in the muscular, rather than the membranous part.

Case of Myelogenous Leukemia in an Infant Nine Months Old

DR. J. H. MASON, Baltimore: The patient was a girl, aged 9 months. The striking feature in the case, besides the age of the patient, was the rapid course of the disease, less than three weeks. There was no enlargement of the lymph nodes or spleen, and no record of hemorrhage or of necrosis of the mucous membrane. The symptoms apparently were entirely referable to the gastro-intestinal tract. The great number of leukocytes in the circulating blood (200,000 per cubic millimeter) is to be accounted for by a possible peripheral infection. The atypical granulations seen with neutrophilic myelocytes as well as in the presence of eosinophilic and basophilic varieties gave evidence that it was a true primary disease of the bone-forming organs.

Current Medical Literature

AMERICAN

Titles marked with an asterisk (*) are abstracted below.

American Journal of Physiology, Baltimore

June, XXXVII, No. 3, pp. 453-517

1 *Active Principles of Different Organs, as Shown in Kymograph Tracings. G. G. Fawcett, J. Rogers, J. M. Rahe and S. P. Beebe, Ithaca, N. Y.
2 *Rate of Oxidation of Enzymes and Their Corresponding Pro-Enzymes. W. E. Burge and E. L. Burge, Chicago.
3 *Effects of Epinephrin Infusion on Vasomotor Irritability. R. G. Hoskins and W. N. Rowley, Chicago.
4 *Distribution of Gastrin in Body. R. W. Keeton and F. C. Koch, Chicago.
5 Researches on Exchange of Energy in Live Animal Tissues. I. Microcalorimetry Applied to Animal Tissues. A. O. de Almeida, Rio de Janeiro.

1. **Active Principles of Organs.**—All the different organs from which the authors prepared extracts, with the exception of the suprarenal, contain a depressor substance within the "residue" portion, which in each case varies in its action directly as its nitrogen content (calculated in terms of protein). The depressor effect of the thyroid "residue" is said to be dependent on a substance containing iodin. When standardized according to its nitrogen content each "residue" produces characteristically different effects in the kymograph tracings. This depressor agent cannot be cholin because a dosage of pure cholin which is comparable to that of a thyroid "residue," for example, produces no effect. The active portion of these "residues" is apparently not the same as Popielski's vasodilatin, which is prepared in a totally different way and gives different reactions.

2. **Rate of Oxidation of Enzymes.**—The Burges summarize their findings as follows: Trypsin is more easily oxidized than trypsinogen. Pepsin is more easily oxidized than pepsinogen. The fact that trypsin and pepsin are relatively easy to oxidize makes it possible for the mucosa of the stomach and intestine to protect itself from digestion by means of its oxidative processes. The fact that trypsinogen and pepsinogen are relatively difficult to oxidize prevents these substances from being oxidized in the cells of the pancreas and of the gastric mucosa during the process of secretion.

3. **Epinephrin and Vasomotor Irritability.**—In forty-four anesthetized dogs the effects of epinephrin infusion on the

irritability of the vasomotor mechanism was investigated by Hoskins and Rowley. The vasomotor mechanism was stimulated by faradization of the sciatic and splanchnic nerves, and by injections of nicotin, epinephrin and pituitary extract, before, during and after intravenous infusion with epinephrin. No concentration of epinephrin gave satisfactory evidence of augmenting vasomotor irritability, or facilitating the transmission of vasomotor impulses. In most cases the infusion lessened the vasomotor irritability—sometimes to a marked degree. The animal's own suprarenal glands played no significant part in the results. The irritability of both the pressor and depressor mechanisms was decreased. The authors conclude that the depression was probably both central and peripheral, hence circulating epinephrin is probably not a factor in the ordinary functioning of the animal economy.

4. **Distribution of Gastrin in Body.**—Evaporation of an acid extract from various tissues leaves a residue, soluble with difficulty, in 95 to 98 per cent. alcohol, which manifests varying degrees of gastrin activity. The gastrin is uniformly distributed throughout the stomach mucosa, is found in much smaller concentrations in the duodenum, and its presence can just be demonstrated in the esophagus. Preparations of pancreas, submaxillary gland, smooth muscle and striated muscle are negative. Gastrin intramuscular doses of 1 c.c. (corresponding to 4 to 5 gm. of fresh tissue) cause a fall in blood pressure lasting over four to five minutes, a secretion lasting over one and one-half hours with a maximum between thirty and forty-five minutes following the injection. The authors believe that gastrin causes a true gastric secretion rather than a simple vasodilator response, that it is of a different chemical nature from pancreatic secretin, and that it is a specific substance.

Bulletin of Johns Hopkins Hospital, Baltimore

June, XXVI, No. 292, pp. 211-240

6 *Accurate Clinical Study of Blood Sugar. S. Strouse, I. F. Stein and A. Wiseley, Chicago.
7 Chorio-Epithelioma of Testicle. J. V. Cooke, San Francisco.
8 Mithridatium and Theriac, Most Famous Remedies of Old Medicine. G. W. Corner, Baltimore.
9 Is Pathologic Metabolism in Parental Organism Responsible for Defective and Monstrous Development of Offspring? E. I. Werber, Princeton, N. J.
10 Medicine in China. R. M. Pearce, Philadelphia.
11 Case of Abscess of Liver, Due to Streptothrix. A. Bloomfield and S. Bayne-Jones, Baltimore.

6. **Study of Blood Sugar.**—The Kowarsky method of determining blood sugar, as modified by the authors, affords an efficient and accurate means of studying blood sugar in man. The normal blood sugar, as shown by a study of sixty-one determinations, varies from 0.04 to 0.12 per cent. (in one instance 0.14 per cent.) with an average of 0.084 per cent. These variations are due to the varying factors in the ordinary day of any normal individual—especially to the diet factor. Carbohydrate in the diet raises the blood sugar. The blood sugar of a normal man describes a curve reaching its lowest limits before breakfast and before dinner, and invariably showing a rise one hour after meals. The authors emphasize the fact that blood sugar determinations, to be of any value, must be performed before and after an ordinary meal containing carbohydrate.

Journal of Experimental Medicine, Lancaster, Pa.

June, XXI, No. 6, pp. 525-652

12 *Study of Barlow's Disease Experimentally Produced in Fetal and New-Born Guinea-Pigs. A. Ingier, Christiana, Norway.
13 *Pure Cultivation in Vivo of Vaccine Virus Free from Bacteria. H. Noguchi, New York.
14 *Transplantation of Tumors to Foreign Species. C. Funk.
15 *Effect of Arsenic Compounds of Rous Chicken Sarcoma. C. Funk.
16 *Antibody Formation Against Treponema Pallidum—Agglutination. H. Zinsser and J. G. Hopkins, New York.
17 *Adult Tertian Malarial Parasites Attached to Peripheral Corpuscular Mounds. Extracellular Relation of Parasites to Red Corpuscles. M. R. Lawson, New London, Conn.
18 *Influence of Digitalis on T Wave of Human Electrocardiogram. A. E. Cohn, F. R. Fraser and R. A. Jamieson, New York.
19 *Effect of Sensitization on Development of Lesions of Experimental Pneumonia in Rabbit. M. B. Kirkbride, Albany, N. Y.
20 Visual Cortex, Its Localization, Histologic Structure and Physiologic Function. E. B. Funkhouser, Trenton, N. J.
21 *Pathogenic Properties of Bacillus Proteus. W. P. Larson and E. T. Bell, Minneapolis.

12. **Barlow's Disease Experimentally Produced.**—Pronounced cases of Barlow's disease were produced by Ingier in the fetus as early as ten to fifteen days after the commencement of dieting pregnant guinea-pigs with oats and water. There are wide individual variations. The scorbutic changes in the skeleton are greatest in the earlier embryonic stages. The fetuses of that period, with practically no exceptions, die and show marked traces of impeded growth. Fetuses from the later period of pregnancy are born alive, and apparently fully developed, with comparatively slight changes in the osseous system. Even a short extension of the period of extra-uterine dieting on milk from scorbutic mothers and later on oats and water is sufficient to change the latent scurvy into a highly pronounced case. The fetus cannot be kept alive longer than the adult animal, about twenty-eight days, either by intra-uterine dieting alone or by combined intra-uterine and extra-uterine dieting. The mothers show signs of disease at an early period, and are more severely attacked than nonpregnant animals. Death also occurs comparatively often in the first period of gestation.

13. **Cultivation of Vaccine Virus.**—Vaccine virus freed from all associated bacteria by means of suitable disinfecting agents was propagated by Noguchi in a pure state in the testicles of rabbits and bulls. The virus cultivated in this manner is not only devoid of all bacteria, but appears capable of indefinite transfer from one animal to another. Sixty passages in rabbits of a pure strain have been made within one year. Several transfers from testicle to testicle are required to bring about accurate adaptation of the virus to the testicular parenchyma, so that continued propagation in this way can be certainly secured. During the first transfers from testicle to testicle the activity of the virus may be less than the original skin specimen from which the pure strain was derived; but as the transfers proceed the activity rises until, when the adaptation is complete, the activity of the testicular equals that of the skin strain. The multiplication of the virus within the testicle is maximum on the fourth or fifth day after inoculation; the quantity of virus remains about stationary until the eighth day, when diminution begins. At the expiration of five weeks no more virus could be dected in the testicle.

The vaccinal processes in the skin, cornea and testicle of rabbits are practically identical whether the virus employed for the inoculation has been the original skin strain or the pure testicular strain; and the skin lesions produced in the calf by means of the two strains are also identical.

Human beings react to the pure testicular strain of vaccine virus in an entirely typical manner. In the case both of original vaccination and revaccination the vaccinal effects cannot be distinguished from those arising from uncomplicated skin virus. Pure strains of testicular virus are readily produced, and once secured they may be propagated in a pure state in rabbits or bulls by the method described, without difficulty and with economy. The pure strains thus obtained should supply an ideal form of virus for employment in the vaccination of human beings.

14. **Transplantation of Tumors to Foreign Species.**—By feeding to rats the tissue of the mouse chondroma, Funk found that they are rendered more suitable as hosts for the growth. Using this method rats have been inoculated successfully with the mouse tumor, and it has been transferred to three successive series of these animals.

15. **Effect of Arsenic Compounds on Rous Chicken Sarcoma.**—Arsenic and arsenious acids, cacodylic acid, atoxyl and neosalvarson failed to influence markedly the growth of the Rous chicken sarcoma.

16. **Antibody Formation.**—It is shown by Zinsser and Hopkins that the serum of rabbits treated with emulsions of *Spirochaeta pallida* contains agglutination substances.

17. **Adult Tertian Malarial Parasites.**—It is claimed by Lawson that the malarial parasite is extracellular throughout its entire life cycle; that is, when it is not free in the blood serum, it is attached to the external surface of the red corpuscle. Adult parasites follow the same procedure in attaching themselves to the outer surface of the red corpuscles, as do the young parasites. Adult parasites are most frequently seen attached to surface corpuscular mounds. Corpuscular mounds projecting at the periphery of the red corpuscles and encircled by the pseudopodia of adult parasites, are proof positive of the extracellular relation of the adult parasite to the red corpuscle. Adult parasites attached to peripheral corpuscular mounds are only found in appreciable numbers when the red corpuscles are not badly damaged, so that the mounds show more or less hemoglobin content. The nuclei or protoplasm of adult parasites extending beyond the periphery of the red corpuscles is additional evidence of the extracellular relation of the parasites to the red corpuscle.

18. **Influence of Digitalis on Human Electrocardiogram.**—It is shown in this investigation that digitalis, administered orally to patients, can modify the T wave in the electrocardiogram. When the T wave in the initial curve is directed upward, the first change noticed is a lowering and the final change is an inversion of the wave. It is not only the wave itself, but that portion of the curve between the end of R and the end of T which is involved. Instances in which the initial T waves have other than upright forms are described and their behavior under the influence of digitalis has been indicated. This influence of digitalis on the T wave may be detected in thirty-six to forty-eight hours after the administration of digitalis has commenced; it may persist as long as twenty-two days after the administration has been stopped. Instances in which it persisted only five days have been encountered. The unexpected length of duration of the sign probably explains why a second treatment with digitalis requires a smaller amount of the drug to produce the same effect than the first.

19. **Experimental Pneumonia in Rabbit.**—Kirkbride's study would seem to give some ground for the view that while in pneumonia a hypersensitive condition probably takes some part in the inception of the infection, the subsequent development of the diffuse exudative reaction in the lung is not directly due to an acquired hypersusceptibility, but to intrinsic qualities possessed by the pneumococcus itself.

21. **Pathogenic Properties of Bacillus Proteus.**—The first proteus strain with which Larson and Bell experimented was isolated from a laparotomy wound in a case which subsequently terminated fatally. The proteus was repeatedly isolated from this patient in pure culture. The second strain was isolated from a severe eye infection following a cataract operation. A third strain was isolated from an infection of the finger, believed to have been contracted at a necropsy. A fourth was isolated from the heart's blood in a case in which the patient had died from peritonitis following a gunshot wound of the intestines. The fifth strain was from a patient with gangrene of the lung. These organisms all proved to be pathogenic for rabbits. All cultures obtained from sources other than human infections were nonpathogenic for the laboratory animals. A nonpathogenic culture may be made pathogenic by the use of aggressins or by inoculation into the anterior chamber of the eye. Proteus cultures lose their virulence rapidly when grown on artificial mediums. The lesions produced in animals are either simple abscesses, proliferative lesions, or a mixed exudative and proliferative lesion. The proliferative lesions consist mainly of epithelioid cells apparently of connective tissue origin. No giant cells of the Langhans type are present. The histologic type of the lesion does not depend on the strain employed. Neither does it bear any relation to the clinical severity of the case. The ability to produce the characteristic lesions has no necessary connection with the toxicity of the bacteria. The authors suggest that the proteus bacteria probably play a more important part in human pathology than is generally believed.

FOREIGN

Titles marked with an asterisk (*) are abstracted below. Single case reports and trials of new drugs are usually omitted.

British Medical Journal, London

May 22, I, No. 2838, pp. 877-916

1 *Treatment of Toxemia of Later Pregnancy; Report of Cases. J. Byers.
2 Dressing Station in France. G. R. Ward.
3 Some Infections of Tonsils. F. C. Pybus.
4 *Successful Sterlization of Skin with Tincture of Iodin. J. L. Stretton.
5 Typhus in Palestine, 1913 to 1914. C. H. Corbett.
6 Admission of Men with Glasses into Army. A. A. Bradburne.

1. **Treatment of Toxemia of Later Pregnancy.**—Byers emphasizes that every effort should be made to relieve the kidneys by getting the skin and bowels to act and by the administration of a simple nonnitrogenous diet. If there be headache or edema the patient, in addition, should be kept in bed and should have hot baths, free purgation and a milk diet; and if the state of affairs becomes more severe, warm saline lavage of the stomach and intestines is useful. In the nephritic cases, if in spite of this method of management the patients get worse, labor should be induced. One of the most important points emphasized is that a pregnant woman's urine must be analyzed once a month during the first six months of gestation, and at least once a fortnight after that period. Since adopting this routine method, Byers has not had in private practice during the past fifteen years a single case of eclampsia, as prompt measures taken when an examination of the urine showed any considerable amount of albumin (under these circumstances a catheter specimen should always be obtained), and with it any diminution in urea and nitrogen output, warded off all risk of convulsions and coma.

4. **Sterilization of Skin with Iodin.**—Stretton claims to have been the originator of this procedure, which he first described Aug. 14, 1909. He has now used the method with satisfaction in upward of 3,000 cases, and has never seen any dermatitis result from the use of the tincture of iodin. There is sometimes a limited amount of desquamation. The solution he originally used was the tincture of iodin (B. P.). It is prepared by dissolving 2.5 per cent. of iodin and 2.5 per cent. of potassium iodid in rectified spirit. In an endeavor to save the funds of the hospital he tried a solution of the same strength in methylated spirit, but soon found that it produced so much irritation and lacrymation that he was obliged to resume the original compound. He now uses the tincture in the theater and a similar solution made with methylated spirit in the wards.

Lancet, London

May 22, I, 4786, pp. 1065-1112

7 *Some Infections of Tonsils. F. C. Pybus.
8 Treatment of Septic Wounds. A. M. Sheild.
9 *Heart Perfusion with Excretory Toxins. D. T. Barry.
10 Influence of Injections of Contratoxin No. 4 (Mehnarto) on Content of Opsonins in Blood Serum of Tuberculous Patients. R. T. Hewlett and L. Rajchmar.
11 Progress in Treatment of Cataract in India. H. Smith.
12 *Two Extraordinary Cases of Liver Abscess. C. B. Pasley.
13 Cerebrospinal Fever and Sphenoidal Sinus. D. Embleton and E. A. Peters.

7. **Some Infections of Tonsils.**—The principles to be adopted in the treatment of tonsillar disease are summed up by Pybus as follows: So far as the individual is concerned, when the symptoms are mainly or entirely mechanical and fail to subside in three months after removal of any source of infection, partial removal may suffice. Tonsillotomy, however, has this disadvantage, the basal portion of the tonsil may enlarge and again cause symptoms. In addition to this, many hypertrophied tonsils, so far as can be ascertained on inspection, do not appear to be grossly infected. In those cases which are grossly infected the basal portion, often the most diseased, is left behind and may commence to give trouble, especially if some of the lacunae become partially or entirely sealed up in the process of healing. When infec-

tive symptoms predominate in the tonsil itself, such as acute tonsillitis or chronic lacuna infection, or when the tonsils are in addition enlarged, any source of infection must be removed, especially carious teeth. Nasal breathing must be reestablished, and the case watched to see the effect of the treatment. In cases in which the tonsil is too severely affected to be capable of recovery, as judged by the recurrence of symptoms and the failure of the above measures, then total removal is indicated.

For lymphatic gland infections, in which tuberculosis is suspected, tonsillectomy is indicated; the course of the glandular enlargement determines whether this also may require operation. In pyogenic infections of the glands the tonsil must be dealt with when the acute lymphadenitis has subsided or been operated on if suppuration has supervened. Chronic glandular enlargement of the mild or moderate degree is so frequently encountered in hypertrophied tonsils that when the tonsil recovers its normal character the glands subside also. It should be a rule that no tonsil should be removed when acutely inflamed. For more distant infections, when the tonsil is suspected of being the focus, removal is indicated when the general condition is satisfactory. The maintenance of nasal respiration, the prevention of dental caries and the proper supply of food in sufficient quality and quantity will greatly diminish the prevalence of this condition. The provision of a cleaner air supply and the prevention of infection by milk are measures needing attention.

9. **Heart Perfusion with Excretory Toxins.**—The heart is exposed to the action of certain excretory toxins of the urine and feces when the mechanism of their expulsion is defective, or it may be, to these toxins of their precursors normally on their way to elimination. This action was tested by Barry by perfusion of the toad's heart. The inferior vena cava below the liver was isolated and a small cannula inserted, communicating with three perfusion bottles; one contained freshly prepared Ringer's solution, the second a mixture of human urine and the third fecal extract made with Ringer's solution. Strengths of 10 and 15 per cent. were tried. The aorta was cut across to provide a free exit of the fluid. The toxicity of these solutions is greatly diminished by boiling and by allowing them to stand for a few days.

The first toxic effect is exhibited by the ventricle. A 10 per cent. urine solution in a few seconds brings about cessation of this chamber in a state of tonus. The auricular beat is increased in force, due in part, at any rate, to increased tension; there was no previous perfusion. Recovery with Ringer's solution is rapid, though the ventricle is somewhat irregular for a time. Fecal extract shows a similar result. There seems to be a certain degree of tolerance of, or immunity from, the toxins on their repeated use. This is exhibited by a slower onset of the effects and a diminution of the toxicity. A certain amount of antagonism seems to exist between these poisons, but the question has not been properly investigated. The a.-v. bundle seems to be the part most affected by the excretory toxins which depress its conductivity, at the same time that they affect somewhat the ventricular muscle as a whole. A marked difference in the mechanism of the two chambers is also demonstrated by their action. Irritability of ventricular muscle is completely lost only with strong solutions and is quickly recovered if the action be not too long continued. The nervous mechanism, except the accelerator fibers, seems to be unaffected by the weaker solutions.

12. **Two Extraordinary Cases of Liver Abscess.**—In the two cases cited by Pasley as worthy of record from the fact of the remarkable size of the abscesses, the patients were extremely emaciated and constitutionally extremely ill. They both recovered perfectly, thus showing that no liver abscess, however large and however ill their possessors may be, can be considered as hopeless. In one case the abdomen was found enormously distended, resembling closely the abdomen at full-term pregnancy. An enormous tumor was palpable, which gave the sensation of fluid under extreme pressure. It was slightly tender to touch. Absolute dulness extended from the pubic region up to and continuous with the hepatic area proper. The tumor extended equally into both umbilical regions laterally—in fact, it practically filled the abdominal cavity. The patient's general condition was extremely bad; he was wretchedly thin, weak and listless. There was absolutely no sign of jaundice and no bile in the urine. Blood examination showed slight leukocytosis. Examination of stools gave a negative result. A provisional diagnosis of liver abscess was made and operation decided on. The patient rapidly improved. No ameba were found in swabbings taken from the abscess cavity. The only medicine given during his illness was emetin administered daily by hypodermic injection. He received 1½ grains per day.

In the second case, on examination, an enormous tumor was found practically filling the entire abdomen. It gave the sensation, on palpation, of a sac containing fluid under very high pressure. So far as could be made out by external palpation the lower margin of the tumor was situated 1½ inches above the symphysis pubis. It extended laterally into each flank and seemed to originate from the liver. Examination of the blood showed a slight leukocytosis. Examination of the feces showed the presence of ankylostoma and ascaris ova. The patient's general condition was wretched. Pasley operated on him. His recovery was uneventful. He received one-half grain emetin hydrochlorid daily for three weeks by hypodermic injection.

Archives de Médecine des Enfants, Paris

May, XVIII, No. 5, pp. 237-292

14 Vaccine Therapy of Whooping-Cough. (La bactériologie et la thérapeutique de la coqueluche.) M. de Biehler.
15 Relations Between the Pulse and the Viscosity of the Blood in Children. (Le rapport sphygmo-viscosimétrique.) P. Gautier.
16 *Primary Tuberculosis Bacillemia in Infants. A. Jousset.

16. Summarized in Abstract *29*, March *27*, p. 1112.

Journal de Chirurgie, Paris

August, 1914, XIII, No. 2, pp. 145-240

17 *Treatment of Acute Diffuse Peritonitis. S. Mercadé.
18 Suppuration in Hand Spreads by Continuity or by the Lymph Vessels. (Pathogénie des phlegmons de la main.) L. Imbert.

17. **Acute Diffuse Peritonitis.**—Mercadé discusses in turn the treatment of the peritoneum after the inevitable laparotomy, the treatment of the general intoxication, treatment also of the paralysis of the bowel and stomach, and treatment of the heart weakness. To combat the general intoxication lavage of the blood is required, and this is best realized by saline solution given in the rectum by the drop method. Some prefer plain boiled water, others sea water; the latter seems to have a pronounced stimulating action, but does not promote diuresis so well as plain water. Solutions of sugar, he says, have little diuretic action, but are nourishing, stimulating and tonic. Schiassi advocates for the purpose a solution of sodium chlorid 6.5 parts; potassium chlorid, 0.3 part; fused calcium chlorid, 1 part; sodium bicarbonate, 0.5 part; glucose, 50 parts; alcohol, 15 parts, and distilled water, 1,000 parts.

Among the nine various measures that can be applied in treatment of paralysis of the bowel, he emphasizes the advantages of electric enemas. They seem especially indicated here to combat the dynamic ileus; they are harmless and if they prove effectual their action is prompt. They should be applied early, so as not to waste much time if they prove ineffectual after two or three applications. If the paralysis extends to the stomach, a retention stomach tube is advocated by Grosser and others, the tube, 4 or 8 mm. in diameter, passed through the nose. Sometimes as much as 4 or 5 liters of fluid are thus brought out of the stomach in the twenty-four hours, and fluids must be supplied in other ways to replace these amounts thus lost. In conclusion, Mercadé points out that we have thus quite a number of measures at our command for carrying a patient through acute general peritonitis, but too many must not be applied at once.

Presse Médicale, Paris

May 6, XXIII, No. 19, pp. 145-152

19 Improvised Extension Splint for Fractures of the Humerus. (Méthode simple de traitement des fractures de l'humérus par armes à feu.) L. Bérard.
20 *Wounds of Peripheral Nerves. (Les lésions traumatiques des nerfs. Considérations opératoires.) L. Imbert.
21 Laboratory Tests for Cholera. L. Lagane.
22 Nomenclature of Bacteria. H. Coupin.
23 Extraction of Projectile Under Control by Roentgen Rays. Lobligeo's.

May 13, No. 21, pp. 161-168

24 *White Spots in the Mouth Usually a Sign of Syphilis. (Les taches blanches de la muqueuse jugale et commissurale, dites "plaques de fumeur," fonction de syphilis.) L. Landouzy.
25 Splint in Treatment of Radial Paralysis. T. Tuffier.
26 *Peritoneal Complications of Typhoid. M. Villaret.

20. **Wounds of Peripheral Nerves.**—Imbert comments on the number of operations now required for wounds of this kind as one of the surprises of the war. He is stationed at Marseilles, and has had to devote three or four mornings a week to operations on peripheral nerves. He does not operate on the nerve until the wound has entirely healed, but then permits no further delay. The study of each case requires the cooperation of a neurologist and histologist with the surgeon. When this is the case the danger of the operation is minimal while the functional outcome is often extremely gratifying.

24. **"Smoker's Patches" in the Mouth.**—Landouzy makes a practice of examining the mouth for the whitish lines or triangular patch on the mucosa extending back from the juncture of the lips toward the first molar known as smoker's commissural patches. He has found them exclusively in syphilitics; the tobacco is merely the local irritant causing the patch to develop in the predisposed. He has found them in women, but never in any except those married to syphilitics or with a history of personal syphilis. Landouzy has been preaching for twenty years the extraordinary, the unbelievable frequency of syphilis, and has found these smoker's patches often the only clue. He examines the mouth of every adult patient, man or woman, and has found these patches on the inside of the cheeks almost constantly in syphilitic smokers, and with extreme frequency in nonsmoking syphilitics in the third phase of the disease, and also in syphilitic women. The patches are liable to retrogress under mercury and iodid, although the smokers make no change in their smoking habits. Since the introduction of the Wassermann test, he applies it regularly to all patients showing these stripes or patches in the mouth. Of 164 syphilitics, the Wassermann was strongly positive in 81 of the 131 showing the patches. In another group of 72 men and 12 women in the third stage of syphilis, 52 of the men and 4 of the women had white patches, and 39 of these men and 2 of the women responded positively to the Wassermann test. He found the commissural leukoplakia also in 15 of 17 young syphilitic soldiers recently encountered; the Wassermann was positive in 9. In short, Landouzy regards these "smoker's patches" as pathognomonic, and as instructive as the Wassermann reaction, while their presence can be determined by merely a glance. He adds that the number of women in whom he has found them now total 15.

26. **Peritoneal Complications of Typhoid.**—Villaret states that perforation has occurred in only about 1.5 per cent. of the 600 cases of typhoid among soldiers in the hospital in his charge, but that all the other possible immediate complications of typhoid were numerous and grave. A purulent otitis or parotitis seemed often to serve as a spontaneous fixation abscess, and hastened recovery. Unless perforation had actually occurred, medical measures brought the men through in 97 per cent. of the cases showing a reaction on the part of the peritoneum. When signs of such a reaction develop, absolute repose and absolutely nothing by the mouth for several days are indicated; the mouth can be frequently rinsed out, and that is all. Ice to the abdomen and over the heart was an important aid in the cure, he is convinced, as also subcutaneous injections of 0.5 or 1 c.c. of a 1:1,000 solution of epinephrin or of 300 or 500 c.c. of saline containing epinephrin. The great value of these injections whenever cardiovascular or peritoneal symptoms became apparent was demonstrated most effectually in the aggravation of conditions throughout the wards when the supply of epinephrin ran out. A tendency to collapse was combated with camphorated oil plus ether, and the septicemia with some colloidal silver preparation subcutaneously, and an artificial fixation abscess. These measures cured 60 per cent. of the men with unmistakable peritonitis, and 97 per cent. of those with a peritoneal reaction which did not progress to actual inflammation.

Berliner klinische Wochenschrift

May 17, LII, No. 20, pp. 509-536

27 *Angina Pectoris. H. Kohn.
28 *Heart Disturbances in War. (Herzstörungen bei Kriegsteilnehmern.) S. Korach.
29 *Vagotony. W. Lublinski.
30 Scientific Management in Factories, Etc., from Psychologic Standpoint. (Zur Psychologie des Wirtschaftslebens.) G. Rosenfeld.
31 *War and Venereal Diseases. (Krieg und Geschlechtskrankheiten.) K. Touton. Commenced in No. 19.
32 Spa Treatment of the Wounded. (Resultate der Badebehandlung von Kriegsverwundeten und Erkrankten.) M. Porges.
33 Bath Trains. (Transportable Badeanstalten.) R. Rauch.

27. **Angina Pectoris.**—Kohn remarks that although Askanazy's work on the efficacy of theobromin in angina pectoris was published twenty years ago, yet few even now realize that theobromin can be relied on in angina pectoris almost as confidently as digitalis can be relied on when the heart action is rapid and weak. In treatment of a pronounced attack of angina pectoris, morphin relieves the pain and relaxes the spasmodic contraction of the coronary arteries. The dose must be 0.01 gm. at least, repeated if improvement does not soon follow. If one already knows the patient, 0.015 or 0.02 might be given to start with. If the pulse is slow or growing slower, stimulants should be injected at the same time, not waiting for signs of pulmonary edema to develop, repeating the camphor or caffein at need. Alcohol can also be used, with moist heat to the heart, placing the hands or feet in hot water, and giving amyl nitrite or nitroglycerin. To ward off attacks, theobromin has fully established its efficacy, he says, in treatment of the fundamental disturbance of which the angina pectoris is the manifestation. It is actually marvelous, he declares, to witness how the theobromin arrests the tendency to repeated mild partial or abortive attacks, the status anginosus as he calls it, in analogy with the status epilepticus. Patients long tormented day after day or night after night, are freed at once from their symptoms by the theobromin. He deplores the lack of general appreciation of the efficiency of theobromin in the treatment of the fundamental disturbances which are the bases for angina pectoris. The patient must stay in bed till all tendency to heart disturbances seems to have subsided; physical exercise should be discouraged and tobacco forbidden.

28. **Soldier's Heart.**—Korach remarks that in scarcely any other affection is it so difficult to decide whether the symptoms are of organic or purely nervous origin as in the heart disturbances encountered among the men in active service. And yet dire harm is likely to be wrought if treatment is applied on the wrong basis. The majority of the men he has seen at Hamburg who were sent back from the front on account of cardiovascular disturbances were suffering merely from purely nervous or functional cardiovascular derangement. Once entirely relieved from physical and emotional stress, the disturbances slowly right themselves in those with previously sound hearts. Differentiation is possible as a rule only with prolonged tranquil study of the case. Neurasthenics with extra systoles and very high blood pressure are not capable of service at the front.

29. **Vagotony.**—Lublinski goes over much the same ground covered by the two articles in THE JOURNAL, Jan. 31 and May 16, 1914, pp. 365 and 1535, and emphasizes that it is easy to recognize the "vagotoniker" at a glance, by the ebb and flow of color in the face, the sudden perspiration, the

cool, damp and bluish hands, the lusterless eyes, the narrow pupil, the drooping corners of the mouth and the frequent swallowing. The abnormally irritable vagus system can be steadied and toned up with atropin, but this must be kept up perseveringly, even when good results are apparent, with ascending and declining dosage. Arsenic is useful also as a tonic for the nerves; it is especially advantageous in the form of an arsenical mineral water.

31. **War and Venereal Diseases.**—This long address was delivered before a mixed audience, and in conclusion Touton reiterated that the compulsory introduction of individual prophylactics is, next to sanification of prostitution, by far the most important means to avoid the weakening of the army from venereal diseases. He quotes a communication from Löb at Mannheim to the effect that under the influence of salvarsan endemic syphilis had been nearly stamped out in that city, as in other smaller centers, but that since the war began there has been an appreciable increase in the number of cases of syphilis. Touton advocates classing the effects of venereal diseases acquired during the war with other war disabilities entitling to a pension. The state insurance has abandoned its former practice of discriminating against such policy-holders, and he urges that soldiers and their families suffering from the results of these diseases should not be treated as criminals or sinners. In short, he concludes, the whole subject of venereal disease during the war should be regarded and managed from the strictly hygienic-medical standpoint, leaving all ethical and esthetic considerations in the background for the time being.

Gazzetta degli Ospedali e delle Cliniche, Milan

May 13, XXVI, No. 38, pp. 593-608

34 *Aleukemic Lymphomatosis. (Le linfosi aleucemiche dal punto di vista clinico.) G. Ghedini.

35 Treatment of Tetanus in the Present War. A. Bertolini.

34. **Aleukemic Lymphosis.**—Ghedini recalls that lymphosis may develop with merely the signs and symptoms, local and general, of more or less severe anemia, with or without enlargement of the spleen, or as a hemorrhagic diathesis, an acute infection, simple lymphadenitis, sarcomatosis of the viscera or bones, or a nodular infiltrating and ulcerating dermatosis, or it may simulate syphilitic or tuberculous lesions. He reports a specimen case of each of these ten different types, and refers to typical examples of each on record. It is evident from his reasearch that in many cases of anemia, with splenomegaly, the underlying lymphomatosis has not been recognized. It may develop with the aleukemic blood picture, and the latter may vary widely from the classical type of lymphomatosis. The morbid blood picture should be studied from a broader standpoint than has hitherto been the case. It should be studied not merely as a disease of the blood-producing apparatus.

Policlinico, Rome

May, XXII, Surgical Section, No. 5, pp. 209-264

36 *Experimental Study of Fat Embolism. (Embolia grassosa.) M. Maccagno.

37 *False Appendicitis. L. Longo. Commenced in No. 4.

36. **Fat Embolism.**—Maccagno injected from 0.5 to 1.5 c.c. of olive oil into a vein in eleven rabbits and the next day killed and examined them to learn the fate of the oil. In others he repeated the injections and did not kill the animals until several days later. Study of the forty-two rabbits thus treated shows that the animals are unable to survive after intravenous injection of an amount equal to 1.06 per thousand of the weight. Also that the fat is only very slowly and defectively eliminated; he found it still present by the fortieth day. The most notable results and those most liable to prove fatal, are pulmonary edema, infarcts, embolism and heart disturbances. The experiences related teach the necessity for absolute repose in cases of fracture suggesting the possibility of fat embolism. Everything should be avoided that might in any way favor the passage of fat into the blood. When a fracture has not been reduced at the time the symptoms of fat embolism are observed, it is better to refrain from further intervention to reduce the fracture until the vessels have become thrombosed, as even a small quantity of fat in the blood vessels is likely to do much damage.

37. **Pseudoappendicitis.**—By this term Longo means any clinical picture which may be mistaken for that of appendicitis. The treatment of course differs for each, but the decision can be made, as a rule, only after the abdomen has been opened. It is especially necessary to examine the surrounding viscera when the appendicitis seems to have started in as a chronic affection and the appendix seems practically sound on direct examination. Besides this type of chronic appendicitis, there is a type in which the symptoms are many and varied, but the appendicitis never becomes fully developed; this group may be called abortive appendicitis. In other cases appendicitis is simulated by the disturbances resulting from Lane's kink; from Jackson's membranous pericolitis; mucomembranous enterocolitis with paroxysmal attacks resembling appendicitis, or the disturbances resulting from abnormal movability and dilatation of the cecum. He reports seven operative cases of this pseudoappendicitis, the operation revealing the appendix nearly or quite sound; in three cases the trouble was a simple membranous pericolitis, in the others the result of dilatation or abnormal movability of the cecum, or pericolitis with complications. The operations had been done in some of the cases on the diagnosis of ileus.

Hygiea, Stockholm

LXXVII, No. 8, pp. 401-464

38 *Present Status of Progressive Paralysis and Tabes. (Luesparalysläran i dess nuvarande läge.) V. Wigert.

39 Case of Erythema with Intense Tuberculin Skin Reaction. K. Frumerie.

38. **Present Status of Paralysis and Tabes.**—Wigert gives tables from the literature showing the proportion of cases of syphilis in which tabes or general paralysis had developed, classified according to the treatment that had been given. It is much to be regretted that the statistics cannot be compared with each other, as the reports vary so widely with respect to numerous points. It is high time, he declares, for compilation of statistics on a uniform basis in order to learn the exact conditions which favor or render impossible the development of tabes and general paralysis later. Cases should be classified in groups with like clinical course and unlike treatment, and also in groups with like treatment and unlike course of the disease. No such compilation is available at present. Certain statistics seem to indicate that treatment actually shortens the interval between infection and the appearance of paralysis or tabes, and this question deserves intensive study. Only one fact seems to stand out as established by the records to date, he remarks, that there is no evidence on hand at present that the usual mercurial treatment of fifteen and twenty years ago had any efficacy as a relative protection against paralysis and tabes. About half the article is devoted to a discussion of the existence of a syphilitic virus with a special affinity for nerve tissue.

Ugeskrift for Læger, Copenhagen

May 20, LXXVII, No. 20, pp. 781-824

40 *Physiology and Pathology of Sports and Competitive Athletics. K. Secher.

41 Medicinal Rash. (Tilfaelde af Atophanexanthem.) A. Kissmeyer.

40. **Competitive Athletics.**—Secher has not found much evidence of harm done by sports and athletics in Denmark, but he thinks that the authorities should interfere to enforce a medical examination before any competitive event of the kind. A number of athletic associations have already provided for this as a routine measure. All athletics should have some medical supervision. By this means it would be possible to keep out of strenuous competitive events those not equal to this strain, although under ordinary conditions they can keep up their athletic work without harm.

Miscellany

Cystitis in Children

R. Fischl is professor of children's diseases at the University of Prague, and in a recent number of the *Prager medizinische Wochenschrift* he reviews his experiences with cystitis in children, especially the cases in which he has been called in consultation and the attending physician had failed to diagnose the bladder trouble. In his service at Prague, every girl child suspected of urinary trouble is catheterized, and boy babies wear a special receptacle to collect the urine. By this systematic investigation, he has found that cystitis is comparatively rare. Only twenty-six cases were found among the 15,000 children examined in the course of twelve years, and in the group were no infants less than a year old. He has also encountered fifteen cases in his private practice, a total of forty-one cases. Only five of the patients were boys. In twelve cases, the family had recognized that the bladder was the seat of the trouble, but in over 50 per cent. of the cases, this had not been suspected. One child of 8 was supposed to have typhoid, as there had been high continuous fever for a week with moderate diarrhea. There was no agglutination, and the only signs of trouble were slight enlargement of the spleen. The urine at first had contained a little albumin, and this gave the clue to the cystitis; under treatment for this the child promptly recovered. In another case of apparent typhoid, the child of 9 had been taken suddenly, after a long walk on a hot day, with high fever and prostration soon accompanied by diarrhea and cough. The aspect and symptoms suggested typhoid except that there was no agglutination; the sudden onset was also unlike typhoid. The discovery of a vulvovaginitis suggested the possibility of bladder trouble, the long walk having possibly contributed to spread the infection to the bladder. Treatment on this assumption soon cured the child.

Another young child had been treated for supposed typhoid for weeks without benefit, while the strict dieting had emaciated the little patient. The fever had been continuous at first and then irregularly remittent. Called in consultation, Fischl noticed the peculiar odor of the urine at once, and the microscope showed evidences of cystopyelitis. It had developed after an attack of diarrhea. As it had not been suspected for so many weeks, it had run into a chronic phase quite refractory to persevering local measures plus hexamethylenamin internally. These brought the temperature down to normal and the general condition improved, but the urine kept turbid and of a putrid odor while the child had the tint of anemia. The urine finally became normal after one injection of an autogenous colon bacillus vaccine, and there has been no relapse to date.

Left untreated too long, cystitis may drag along for years, or lie latent until roused by pregnancy or other period of stress. Fischl warns that urates in the urine are liable to simulate the cloudiness of cystitic urine. Powder used to dust the genitals of infants may also get into the urine and prove misleading. In one case a bright 5-year-old boy became incontinent and wet his clothes both day and night. The enuresis was not affected by the various methods of treatment applied in turn. No one thought of examining the urine under the microscope. When finally this was done, findings suggestive of cystitis pointed the way to a prompt and speedy cure of both the cystitis and the enuresis.

Fischl gives hexamethylenamin internally in doses of at least 0.5 gm. per day for young infants, and keeps it up until the urine is normal; a week usually answers the purpose. If the desired result is not attained in one or two weeks, it is useless to keep it up longer, and local measures should be applied. He begins with a weak solution of potassium permanganate. If this proves ineffectual, he changes to a 1:5,000 silver nitrate solution. The fresh urine with cystitis is so often neutral that there is no reason for treating with alkalies, as Thomson advocates.

Effect of Pasteurization on the Cream Line

Complaints were made to the New York City Board of Health, following the enforcement of certain regulations concerning the temperature at which milk should be pasteurized by milk distributors, that the cream did not properly rise or separate in the pasteurized product and show a distinct line between the cream and the milk. In order to determine the effect of pasteurization at different temperatures and for different periods, a series of tests was instituted under the supervision of the New York board at the different pasteurizing plants, using different methods and different apparatus, and the results are set forth in Reprint 27 of the board by Charles H. Kilbourne, supervising inspector of foods. Details of the tests, the temperatures, apparatus, time and other conditions are given in detail, and some obscure and as yet not entirely explainable phenomena are described in respect to the cream line in the pasteurizing process. The results, however, are summarized by Kilbourne as follows: All tests indicated that when the milk is cleaned by a centrifugal clarifier, the volume of cream in the milk is reduced from 2 to 3 per cent. The volume of cream in bottled milk is influenced by (1) the temperature to which the milk is heated; (2) the length of time the milk is held at the high temperature; (3) the temperature of the heating medium with which the milk comes in contact during the heating process; (4) the clarification of the milk; (5) the type of apparatus used in treating the milk, and (6) the amount of agitation to which the milk is subjected, especially while hot. The last factor is said to have considerable influence, and in one instance in which the cream line was considerably reduced in the process, the experiment was made of reducing the speed of the agitator which kept the hot milk in motion, when it was found that the cream line remained normal. It was also found that in the processes in which there was most agitation or pumping of the hot milk, most difficulty with the cream line was experienced. Other factors which have an influence are said to be the age of the milk before pasteurization, the grade of cows producing the milk, and the freezing or nonfreezing of the milk before being treated. It is stated that milk may be heated to 145 F. for thirty minutes without producing any injurious effect on the cream line.

Sanitary Works in Argentina

The manner in which the problems of water supply and sanitation have been met in Argentina, particularly in Buenos Aires, is described in *Commerce Reports* for April 14. Buenos Aires is said to present points of resemblance to Chicago. Both are decidedly modern cities which received their greatest accessions of population in recent years, and each is situated on a large body of fresh water. In respect to water supply and drainage, Buenos Aires has the advantage over the northern city in that the waters of the Rio de la Plata move toward the sea, and that the winters in Buenos Aires are never so cold that the danger of frozen water pipes and mains needs to be reckoned with.

The scientific study of water supply and drainage for Buenos Aires dates from 1873, when the population was something over 200,000 (it is now over 1,500,000). The sanitary work now partly completed and partly still under construction is supposed to insure a proper drainage and water supply to meet the city's needs up to 1952, at which time it is prophesied that the population will be near to 6,000,000. The consumption of water allowed per inhabitant per day is 300 liters (nearly 80 gallons), an amount considerably above the rate of the actual present consumption.

While some of the water used in Buenos Aires is as yet obtained from driven wells, these are to be done away with and the entire city supplied with water from the Rio de la Plata. By means of sedimentation, coagulation and filtration, it has been found possible to purify the river water absolutely and render it suitable for all purposes.

Since Buenos Aires is situated on the edge of the river, with no natural elevation from which distribution of water to the city might be effected, it has been necessary to con-

struct elevated distributing stations. Four new centers of distribution are planned. From a water tower in the river, an intake tunnel will conduct the water to the pumping stations on shore, whence it will pass, first to the decanting reservoirs, then to the filter beds, and thence to the gravity tanks and reserve tanks, from which a network of water mains will lead it to all parts of the city. The capacity of the tanks, compared with the amount of water consumed in one day, is much less than in New York or London, owing to the high price of land in Buenos Aires and the lack of natural elevations, which have rendered the cost of such large tanks prohibitive. The use of the coagulation method has counterbalanced this difficulty, however, and provision has been made for a proper reserve of filtered water, so that the city will not suffer for water in case the filter beds and coagulation tanks should be temporarily out of service.

The sewage of Buenos Aires is discharged into the Rio de la Plata at a point far enough below the intake to preclude the possibility of contamination of the water supply.

The water supply and drainage of the federal district (Buenos Aires) is under the control of the National Department of Sanitation (Obras Sanitarias de la Nación) which may also, at the request of the provincial cities, undertake similar work on their behalf. This department is autonomous, being responsible only to the president of the republic, who, with the approval of the senate, appoints the members of its directorate, consisting of a president, a vice president and five other members who serve for a term of four years. This directorate is given liberal powers, both administrative and financial. It has the authority to nominate and discharge all subordinates and to raise money, when necessary, for constructive work, by means of loans secured by the property of the department. These loans are finally to be discharged from the income of the department, which is drawn in part from the national lottery and in part from monthly taxes on all houses which receive water and sewage service. These taxes consist of 3 per cent. on the rental value for the water and 2 per cent. for the sewage. This income is sufficient to meet amortization and interest payments and finally to wipe out the entire debt contracted for the work under process of construction.

The Death Rate in Berlin Last Year

The mortality in Berlin was a little higher in 1914 than in 1913; per thousand inhabitants, 14.54 per cent. died in 1914 to 13.48 in 1913. In this calculation, however, the great changes in the populace after the outbreak of the war must be borne in mind. The increase in the mortality for 1914 included 996 males and 592 females, but classifying the deaths by ages shows that the increase was mostly among infants or the aged. This grouping is evident also in the classification according to the causes of death. The increase, namely, is in catarrhal bowel troubles and diarrhea, measles and pertussis, while the figures for scarlet fever and diphtheria are about the same. There was a moderate increase in the mortality from pulmonary tuberculosis, which does not affect to such an extent the very young or the very old. The pneumonia mortality showed a considerable increase, mostly among the elderly. The number of deaths from senile debility also materially increased, as also the number of deaths from cancer.

The influence of the seasons is instructive. In 1914 the mortality in the winter and spring was above the average; from June to November it was moderate. It used to be the rule that the summer months had the highest mortality on account of the high death rate among infants in the heated term. But now the mortality among infants does not form such a large proportion of the total—partly owing to the influence of the declining birth rate—and hence it is not so important a factor in the general mortality.

During 1914, notwithstanding the unusual decline in the birth rate, the infant mortality was notably higher. There were 5,846 deaths among infants, 37,493 living children born in 1914 to 5,607 deaths, and 40,481 living children born in 1913. But even taking this into account, July, August and September, although they showed the highest death rate among infants, did not have so high a total mortality as the months of the winter and spring. The total rate in July was only 13.66 per thousand, the lowest month in the year. More than the heat of the summer, the inclement weather of the winter and early spring claimed more victims in 1914.

Opportunities for Graduate Work

An interesting sketch of medical impressions on a trip around the world was published recently by Dr. J. Eduque in the *Revista Filipina de Medicina y Cirujia* on his return from a tour for inspection of the clinics and hospitals of Europe and America, made under the auspices of the University of the Philippines. In conclusion Eduque summarizes his impressions in the advice to go to Austria to study pathology, diagnosis and specialties, to England for anatomy and physiology, to France for urology and to the United States for surgery. He urges the necessity for studying the language before leaving home, and strongly advocates the joining of the local medical association open to foreigners, as this provides numerous advantages in the way of opportunities and information. His sketch is republished in the *Prensa Medica* of Havana. He relates that the queen of Bulgaria had planned to come to America and bring several young women with her to study the system of trained nurses here as she had been much impressed with their work in the Red Cross units during the last Balkan War.

The Hospital for Industrial Diseases in Italy

The hospital and clinic for the exclusive study and treatment of the industrial diseases, at Milan, has just completed its fourth year of work. It is the first and to date the only institution of the kind for occupational diseases, and the postgraduate courses have attracted medical men from other countries. Prof. L. Devoto is director and is editor of the little monthly, *Lavoro*, published by the clinic, although antedating it by four years. The expense of running the hospital and clinic is $17,000 a year. The number of days of hospital treatment has averaged 18,720 per year. In April, as an average month, 228 persons were given treatment in the dispensary, including 98 women; and 16 men and 14 women were admitted to the hospital. Wassermann tests were applied in 43 cases, with positive findings in 15. Roentgen-ray examinations were made in 63 cases—all without charge. The institution has prepared sets of lantern slides which they sell for $4 a dozen. They portray various features of industrial diseases and means to recognize and avoid them, tables of statistics, etc., from various countries, and other data bearing on occupational disorders.

Biologic Diagnosis by Means of Intermediate Host

E. Brumpt is professor of parasitology in the medical school at São Paulo, Brazil, and he has recently worked out a method for diagnosis which he calls xenodiagnosis, from the Greek ξένος, host, as he utilizes the intermediate host of the parasite or some vicarious host for the cultivation of the parasite in question. He has applied the method to date mostly in cultivation of Chagas' trypanosome. A Brazilian leech was found convenient for the purpose; the trypanosomes taken up as it sucks blood multiply amazingly in the stomach. But for Chagas' disease, the true intermediary host is preferable. The bite of the bug in question, which is the host of Chagas' trypanosomes, is not painful, and consequently children do not object to let it be placed on them to bite and draw blood. It takes up from ten to five hundred times as much blood as could be examined with the microscope, and the bug, a large black insect with red markings, can then be set aside in a labeled tube and examined at leisure as the trypanosomes proliferate in its interior. Brumpt's communication is the leading article in the *Annaes Paulistas de Medicina*, 1914, iii, 97.

JOURNALS INDEXED IN THE CURRENT MEDICAL LITERATURE DEPARTMENT JANUARY-JUNE, 1915

The following journals have been indexed in the Current Literature Department of THE JOURNAL during the past six months. Any of the foreign journals, except those starred, will be lent by THE JOURNAL to subscribers in the United States and to Fellows of the American Medical Association for a period not exceeding three days. Only one journal may be borrowed at a time. Requests for periodicals should be addressed to the Library of the American Medical Association and six cents in stamps should be enclosed. This covers the average expense of mailing a journal. Domestic journals can be obtained by sending the approximate amount direct to the respective publishers. Thus most of the journals indexed are accessible to the general practitioner, no matter where he may be located.

Albany Medical Annals. M. $2. 170 Washington Ave., Albany, N. Y.
American Journal of Anatomy. Bi-m. $5. 36th St. and Woodland Ave., Philadelphia.
American Journal of Diseases of Children. M. $3. American Medical Association, 535 N. Dearborn St., Chicago.
American Journal of Insanity. Q. $5. Johns Hopkins Press, Baltimore.
American Journal of the Medical Sciences. M. $5. Lea & Febiger, 706 Sansom St., Philadelphia.
American Journal of Obstetrics and Diseases of Women and Children. M. $5. Wood & Co., 51 Fifth Ave., New York.
American Journal of Orthopedic Surgery. Q. $3. P. Blakiston's Son & Co., 1012 Walnut St., Philadelphia.
American Journal of Physiology. M. $5. Johns Hopkins Medical School, Baltimore, Md.
American Journal of Public Health. M. $3. 755 Boylston St., Boston.
American Journal of Roentgenology. M. $5. 32 Adams Ave., West, Detroit.
American Journal of Tropical Diseases and Preventive Medicine. M. $2. P. O. Drawer 602, New Orleans, La.
Annales de gynécologie et d'obstétrique. M. 22 francs. Paris.
Annales de médicine. M. 23 francs. Paris.
Annals of Ophthalmology. Q. $4. Mermod-Jaccard Bldg., St. Louis.
Annals of Otology, Rhinology and Laryngology. Q. $4. Mermod-Jaccard Bldg., St. Louis.
Annals of Surgery. M. $5. J. B. Lippincott Co., E. Washington Square, Philadelphia.
Annals of Tropical Medicine and Parasitology. Q. $5. Liverpool.
Archiv für Gynäkologie. Irregular. Price varies. Berlin.
*Archiv für Kinderheilkunde. Irregular. 15 marks. Stuttgart.
Archiv für klinische Chirurgie. Irregular. Price varies. Berlin.
Archiv für Verdauungs-Krankheiten. Bi-m. 24 marks. Berlin.
Archives of Diagnosis. Q. $1. 250 W. 73d St., New York.
Archives of Internal Medicine. M. $4. American Medical Association, 535 N. Dearborn St., Chicago.
*Archives des maladies de l'apparcil digestif et de la nutrition. M. 14 francs. Paris.
Archives des maladies du cœur, des vaisseaux et du sang. M. 17 francs. Paris.
*Archives de médecine des enfants. M. 18 francs. Paris.
Archives mensuelles d'obstétrique et de gynécologie. M. 25 francs. Paris.
Archives of Ophthalmology. Bi-m. $5. G. P. Putnam's Sons, 27 W. 23d St., New York.
Archives of Pediatrics. M. $3. E. B. Treat & Co., 241 W. 23d St., New York.
Archives of Roentgen Ray. M. $4.50. London.
Arizona Medical Journal. M. $2. Phoenix, Ariz.
*Beiträge zur Geburtshilfe und Gynaekologie. Irregular. Price varies. Leipsic.
Beiträge zur Klinik der Tuberkulose. Irregular. 16 marks. Würzburg.
*Beiträge zur klinischen Chirurgie. M. Price varies. Tübingen.
Berliner klinische Wochenschrift. W. 24 marks. Berlin.
Boston Medical and Surgical Journal. W. $5. 126 Massachusetts Ave., Boston.
Brain: A Journal of Neurology. Irregular. $4. London.
Brazil Medico. W. 20 milreis. Rio de Janeiro.
Bristol Medico-Chirurgical Journal. Q. $3.
British Journal of Children's Diseases. M. $5. London.
British Journal of Surgery. Q. $6.50. William Wood & Company, 51 Fifth Ave., New York.
British Journal of Tuberculosis. Q. $1.25. London.
British Medical Journal. W. $8.50. London.
Bulletin de l'Académie de médecine. W. 20 francs. Paris.
Bulletin of the Johns Hopkins Hospital. M. $2. Baltimore.
Bulletin of the Lying-in Hospital of the City of New York. Irregular. $1. 23 E. 93d St., New York.
Bulletin of the Medical and Chirurgical Faculty of Maryland. M. $0.25. 1211 Cathedral St., Baltimore.
California State Journal of Medicine. M. $1. Butler Bldg., San Francisco.
Canadian Medical Association Journal. M. $5. 145 Wellington St., W., Toronto.
Centralblatt für die Grenzgebiete der Medizin und Chirurgie. Irregular. 22 marks. Jena.
Cleveland Medical Journal. M. $2. 2318 Prospect Ave., Cleveland.
Colorado Medicine. M. $2. Metropolitan Bldg., Denver.
Correspondenz-Blatt für schweizer Aerzte. W. 22 francs. Basel.
Deutsche medizinische Wochenschrift. W. 32 marks. Berlin.
*Deutsche Zeitschrift für Chirurgie. M. Price varies. Leipsic.
*Deutsches Archiv für klinische Medizin. Irregular. Price varies. Leipsic.
Dublin Journal of Medical Science. M. $5.
Edinburgh Medical Journal. M. $6.
Gazzetta degli ospedali e delle cliniche. Semi-w. 25 francs. Milan.
Glasgow Medical Journal. M. $5.
Grèce médicale. Semi-m. 12 francs. Athens.
Hospitalstidende. W. 27.5 kronen. Copenhagen.
Hygiea. M. $5. Stockholm.
Illinois Medical Journal. M. $2. 3338 Ogden Ave., Chicago.
Indian Journal of Medical Research. Q. $2.50. Calcutta.
Indian Medical Gazette. Bi-m. $5. Calcutta.
Jahrbuch für Kinderheilkunde. M. 36 marks. Berlin.
Journal d'urologie médicale et chirurgicale. M. 40 francs. Paris.
Journal of Abnormal Psychology. Bi-m. $4. R. G. Badger, 194 Boylston St., Boston.
Journal of the American Medical Association. W. $5. 535 N. Dearborn St., Chicago.
Journal of the Arkansas Medical Society. M. $1. 810 State Bank Bldg., Little Rock, Ark.
Journal of Biological Chemistry. M. $3. 2419 York Road, Baltimore.
Journal of Cutaneous Diseases. M. $5. Rebman Company, 141 W. 36th St., New York.
Journal of Experimental Medicine. M. $5. Rockefeller Institute for Medical Research, 66th St. and Avenue A, New York.
Journal of the Florida Medical Association. M. $1.00. 334 St. James Bldg., Jacksonville, Fla.
Journal of the Indiana State Medical Association. M. $1. 219 W. Wayne St., Fort Wayne, Ind.
Journal of Infectious Diseases. Q. $5. 57th St. and Greenwood Ave., Chicago.
Journal of Iowa State Medical Society. M. $2. Washington, Ia.
Journal of Kansas Medical Society. M. $2. 501 Husted Bldg., Kansas City, Kan.
Journal of Laryngology, Rhinology and Otology. M. $5. London.
Journal of Maine Medical Association. M. $2. Portland, Maine.
Journal of Medical Association of Georgia. M. $1. Harison Bldg., Augusta, Ga.
Journal of Medical Research. M. $4. 240 Longwood Ave., Boston.
Journal of Medical Society of New Jersey. M. $2. 252 Main St., Orange, N. J.
Journal of Michigan State Medical Society. M. $2. 91 Monroe Ave., Grand Rapids, Mich.
Journal of Missouri State Medical Association. M. $2. 3525 Pine St., St. Louis.
Journal of Nervous and Mental Diseases. M. $5. 64 W. 56th St., New York.
Journal of Obstetrics and Gynecology of the British Empire. M. $6.25. London.
Journal of Oklahoma State Medical Association. M. $2. Muskogee.
Journal of Outdoor Life. M. $1. 289 Fourth Ave., New York.
Journal of Parasitology. Q. $2. Urbana, Ill.
Journal of Pathology and Bacteriology. Q. $5.50. Cambridge, Eng.
Journal of Pharmacology and Experimental Therapeutics. Bi-m. $5. 2419 York Road, Baltimore.
Journal of the Royal Naval Medical Service. Q. $1. London.

W.—Weekly; M.—Monthly; Semi-m.—Semi-monthly; Bi-m.—Bi-monthly; Q.—Quarterly. *Cannot be loaned.

Journal of Sociologic Medicine. Bi-m. $3. 52 N. Fourth St., Easton, Pa.
Journal of South Carolina Medical Association. M. $2. Anderson, S. C.
Journal of Tennessee State Medical Association. M. $2. Jackson Bldg., Nashville, Tenn.
Journal of Tropical Medicine and Hygiene. Semi-m. $5. London.
Journal-Lancet. Semi-m. $2. 839 Lumber Exchange, Minneapolis.
Kentucky Medical Journal. M. $2. Atherton Bldg., Bowling Green, Ky.
Lancet. W. $8. London.
Lancet-Clinic. W. $3. Main near Seventh St., Cincinnati.
Laryngoscope. M. $5. 3858 Westminster Place, St. Louis.
Lyon chirurgical. M. 25 francs.
Lyon médical. W. 20 francs.
Medical Record. W. $5. W. Wood & Co., 51 Fifth Ave., New York.
Medizinische Klinik. W. 32 marks. Berlin.
Military Surgeon. M. $3.50. 535 N. Dearborn St., Chicago.
Mitteilungen aus den Grenzgebieten der Medizin und Chirurgie. Irregular. 25 marks. Jena.
Mitteilungen aus der medizinischen Fakultät der Kaiserlichen Universität zu Tokyo. Irreg. Price varies. Tokio.
Modern Hospital. M. $3. Metropolitan Bldg., St. Louis.
Monatsschrift für Geburtshülfe und Gynäkologie. M. 42 marks. Berlin.
Monatsschrift für Kinderheilkunde. M. 20 marks. Leipsic.
Münchener medizinische Wochenschrift. W. 32 marks. Munich.
Nederlandsch Tijdschrift voor Geneeskunde. W. 10.50 florins. Amsterdam.
New Mexico Medical Journal. M. $2. P. O. 23, Las Cruces, N. M.
New Orleans Medical and Surgical Journal. M. $2. 1551 Canal St., New Orleans.
New York Medical Journal. W. $5. A. R. Elliott Publishing Co., 66 W. Broadway, New York.
New York State Journal of Medicine. M. $1. 17 W. 43d St., New York.
*Nordiskt Mediciniskt Arkiv. Irregular. 30 marks. Stockholm.
Norsk Magazin for Lægevidenskaben. M. $5. Christiania.
Northwest Medicine. M. $2. Cobb Bldg., Seattle, Wash.
Ohio State Medical Journal. M. $2. 207 E. State St., Columbus, Ohio.
Old Dominion Journal of Medicine and Surgery. M. $2. 116 E. Franklin St., Richmond, Va.
Ophthalmic Record. M. $4. 7 W. Madison St., Chicago.
Ophthalmology. Q. $5. 711 Cobb Bldg., Seattle, Wash.
Pediatria. M. 12.50 lire. Naples.
Pennsylvania Medical Journal. M. $2. Athens, Pa.
Philippine Journal of Science. Irregular. $7. Manila, P. I.
Policlinico. W. 32 lire. Rome.
Practitioner. M. $6.50. London.
Presse médicale. Semi-w. 15 francs. Paris.
Public Health Journal. M. $2. York Publishing Co., Lumsden Bldg., Toronto.
Quarterly Journal of Medicine. $6.50. London.
Revue médicale de la Suisse romande. M. 14 francs. Geneva.
Revue mensuelle de gynécologie, d'obstétrique et de pédiatrie. M. 12 francs. Paris.
Riforma medica. W. 35.50 lire. Naples.
Sei-I-Kwai. M. $2. Tokio.
Semana médica. W. $5. Buenos Aires.
Southern Medical Journal. M. $2. 905 Van Antwerp Bldg., Mobile, Ala.
Southwest Journal of Medicine and Surgery. M. $1. El Reno, Okla.
Surgery, Gynecology and Obstetrics. M. $5. Surgical Publishing Co., 31 N. State St., Chicago.
Svenska Läkaresällskapets Handlingar. Irregular. 7.50 kronen. Stockholm.
Texas State Journal of Medicine. M. $1.50. Western National Bank Bldg., Fort Worth, Tex.
Therapeutische Monatshefte. M. 12 marks. Berlin.
Therapie der Gegenwart. M. 14 marks. Berlin.
Tumori. Bi-m. 25 lire. Rome.
Ugeskrift for Læger. W. 20 kr. Copenhagen.
United States Naval Medical Bulletin. Q. $1. Washington, D. C.
Upsala Läkareförenings Förhandlingar. Irregular, 10 kr.
Washington Medical Annals. Bi-m. $1. 2114 18th St., N. W., Washington, D. C.
West Virginia Medical Journal. M. $1. Wheeling, W. Va.
Wiener klinische Wochenschrift. W. 24 marks. Vienna.
Wisconsin Medical Journal. M. $2. Goldsmith Bldg., Milwaukee.
Zeitschrift für Geburtshülfe und Gynäkologie. Irregular. Price varies. Stuttgart.
*Zeitschrift für Kinderheilkunde. Irregular. 18 marks. Berlin.
*Zeitschrift für klinische Medizin. Irregular. 16 marks. Berlin.
*Zeitschrift für Urologie. M. 30 marks. Berlin.
Zentralblatt für Chirurgie. W. 30 marks. Leipsic.
Zentralblatt für Gynäkologie. W. 30 marks. Leipsic.
Zentralblatt für innere Medizin. W. 30 marks. Leipsic.

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EXPLANATION OF THE USE OF THE INDEX

This is an index not only to the reading matter in THE JOURNAL, but also to original articles in the principal medical periodicals of this and other countries. The reading matter appearing in THE JOURNAL is distinguished by the use of **black-faced numerals.**

The letters used to explain in which department the matter indexed appears are as follows: "E," Editorial; "C," Correspondence; "T," Therapeutics; "MI," Medicolegal; "P," Propaganda for Reform; "ME," Medical Economics; "ab," abstract; the star (*) indicates an "Original Article" in THE JOURNAL.

This is a subject index and one should, therefore, look for the chief word, with the following exceptions: "Book Notices," "Deaths" and "Society Proceedings" are indexed under these titles at the end of the letters "B," "D" and "S." Matter pertaining to the Association is indexed under "American Medical Association."

All matter is indexed under the most important word of the heading used in THE JOURNAL, and also under the subject heading. For instance, abscess of the brain will be found under "abscess," as well as under "brain." Such titles as "ocular manifestations, etc." have been indexed under "Eye." Cross references have been liberally used.

The figures in parentheses refer to the paragraph, the number following to the page in THE JOURNAL.

ABDERHALDEN serodiagnosis, present status of, *1898

This reference is to an original article in THE JOURNAL, as shown both by the star and by the black-faced numerals indicating the page.

ACONITE in pneumonia, 1782

This reference, as indicated by the black-faced figures, is also in THE JOURNAL, and on turning to page 420 we find an answer to a question in the Department of Queries and Minor Notes.

ACID, uric, in blood, colorimetric determination of, (84) 1877

In this reference, the (84) indicates that the article is in the Current Literature Department and the fact that the page number is in black-faced type shows that the article is abstracted and discussed in THE JOURNAL. Turning to page 1877 we find (84) refers to an article by S. R. Benedict in the *Journal of Biological Chemistry*, April.

ABSCESS, brain, after blocking trigeminal nerve for removal of teeth, (97) 1690

The fact that in this last reference the page is given in ordinary type indicates that only the title of the article is given. Turning to page 1690 we find that the numeral (97) refers to a paper on that subject by F. Bannes which appeared in *Medizinische Klinik*, April 4.

In the AUTHOR'S INDEX are the names of the authors of articles which have appeared in THE JOURNAL of the American Medical Association and of articles that have been listed from week to week in the Department of Current Medical Literature as having appeared in other journals. The black-faced numerals indicate that the article is in THE JOURNAL, either in full or in abstract. The star (*) preceding the page number, indicates an original article.

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SOCIETIES

Acad.—Academy.
Am.—American.
A.—Association.
Conf.—Conference.
Cong.—Congress.
Conv.—Convention.
Internat.—International.
M.—Medical, Medicine.
Phar.—Pharmaceutical.
S.—Society.
Surg.—Surgical, Surgery, Surgeon.

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Fracture of Left Carpal Scaphoid and Dislocations of Semilunar—Deformity from use of splint; x-ray examination; five illustrations.

Dislocation of Left Unciform Bone.—Two illustrations.

Dislocation of Right Semilunar Bone and Fracture of Right Ulnar Styloid Tip — Fracture of Left Ulna in its Upper Third. Seven illustrations.

Talk on Appendicitis—High hospital mortality; clean-cut early symptoms; disappearance of pain and temperature.

Intestinal Obstruction from Large Gallstone — Increase in frequency of vomiting attacks; borborygmi; differentiation between strangulation and obturation ileus; operation.

Causes of Unsuccessful Gastro-Enterostomy for Ulcer—Suggestions for better technic (clinical talk by Dr. Wm. J. Mayo).

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Tenosynovitis of left wrist (sheath of extensor pollicis involved). Excision of inflamed sac and underlying periosteum. Formation of a new bed for the tendon by turning a pedicled flap of subcutaneous fat and fascia over the denuded bone, between it and the tendon.

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SOCIETY	PRESIDENT	SECRETARY	ANNUAL MEETING
AMERICAN MEDICAL ASSN...	Victor C. Vaughan, Ann Arbor, Mich.	Alex. R. Craig, 535 N. Dearborn St., Chicago	
American			
Academy of Medicine	John L. Heffron, Syracuse	Charles McIntire, Easton, Pa	San Fran., June 25-28, '15
Academy of Ophth. and Oto-Lar..	Jos. C. Beck, Chicago	Lee M. Francis, 575 Delaware Ave., Buffalo..	Chicago, Oct. 5-7, 1915.
Association of Anatomists	G. C. Huber, Ann Arbor, Mich..	C. R. Stockard, Cornell Univ. M. C., New York	Chicago, Dec. 27-29, '15.
Assn. of Genito-Urinary Surg's..	F. R. Hagner, Washington, D. C.	R. ... O'Neil, 379 Beacon St., Boston	
Assn. of Obstetricians and Gyn..	Charles L. Bonifield, Cincinnati..	E. Gustav Zinke, 4 W. 7th St., Cincinnati	1915
Assn. of Path. and Bacteriologists	Leo Loeb, St. Louis	H. C. Ernst, Harvard Med. School, Boston	
Association of Railway Surgeons.	Geo. F. Beasley, Lafayette, Ind...	Louis J. Mitchell, 29 E. Madison St., Chicago	Chicago, Oct. 13-15, 1915
Climatological and Clin. Assn....	Henry Sewall, Denver	Guy Hinsdale, Hot Springs, Va	
Dermatological Association	Sigmund Pollitzer, New York....	Oliver S. Ormsby, 25 E. Washington St., Chicago	
Electro-Therapeutic Association..	John W. Torbett, Marlin, Texas.	J. W. Travell, 27 E. 11th St., New York	At. City, Sept. 14-16,'15
Gastro-Enterological Association..	Chas G. Stockton, Buffalo	F. W. White, 322 Marlborough St., Boston...	1916
Gynecological Society	Thos. J. Watkins, Chicago	LeRoy Broun, 148 W. 77th St., New York....	
Laryngological Association	Alex. W. McCoy, Philadelphia....	Harmon Smith, 44 W. 49th St., New York..	
Laryn., Rhin. and Otol. Society..	Robert Levy, Denver, Colo	Thos. J. Harris, 104 E. 40th St., New York..	
Medico-Psychological Association.	Edw. N. Brush, Towson, Md.	Charles G. Wagner, Binghamton, N. Y.	
Neurological Association	L. F. Barker, Baltimore	Henry C. Eyman, Massillon, Ohio	New Orleans, 1916.
Ophthalmological Society	M. H. Post, St. Louis, Mo....	W. M. Sweet, 1205 Spruce St., Philadelphia	New London, Conn., July 6-7, 1915.
Orthopedic Association	Geo. B. Packard, Denver	R. R. Fitch, 365 East Ave., Rochester, N. Y.	
Otological Society	Chas. W. Richardson, Washington	John B. Rae, 247 W. 70th St., New York	
Pediatric Society	Rowland G. Freeman, New York.	S. S. Adams, 1801 Conn. Ave., Wash., D. C.	1916
Physicians, Association of	Henry Sewall, Denver	Geo. M. Kober, 1819 Q St., Washington, D. C.	1916
Physiological Society	W. B. Cannon, Boston	C. W. Greene, State Univ., Columbia, Mo.	Boston, Dec. 27-30, 1915.
Proctologic Society	Louis J. Krouse, Cincinnati, O...	A. J. Zobel, Shreve Bldg., San Francisco	
Psychopathological Association...	Alfred Reg. Allen, Philadelphia..	L. E. Emerson, Cambridge	
Public Health Association	William T. Sedgwick, Boston ...	Selskar M. Gunn, 755 Boylston St., Boston..	Rochester, Sept. 7-10, 1915.
Roentgen Ray Society	Alfred L. Gray, Richmond, Va...	W. F. Manges, 264 S. 16th St., Philadelphia	1915
Society of Amer. Bacteriologists..	D. H. Bergey, Philadelphia	A. Parker Hitchens, Glenolden, Pa	Spec. Mtg., S. Fran., Aug. 3-5; Urbana, Dec. 28-30, '15
Assn. for S. & P. of Inf. Mort..	Homer Folks, New York	Philip Van Ingen, N. Y. City	
		Ex. Sec., Miss G. B. Knipp, 1211 Cath. St., Balt.	
Society of Tropical Medicine	Capt. Chas. F. Craig, U. S. A....	John M. Swan, 457 Park Ave., Rochester, N. Y.	
Surgical Association	George E. Armstrong, Montreal..	Robt. G. LeConte, 1530 Locust St., Phila	
Therapeutic Society	F. M. Pottenger, Monrovia, Cal..	Lewis H. Taylor, The Cecil, Washington, D. C.	
Urological Association	E. L. Keyes, Jr., New York City	Henry L. Sanford, Osborn Bldg., Cleveland...	St. Louis, 1916.
Assn. of Military Surg's of the U. S.	Col. J. R. Kean, Ft. Leavenworth, Kan.	S. C. Stanton, 535 N. Dearborn St., Chicago	Washington, D. C., 1915.
Cong. Am. Phys. & Surgs. of N. A.	Wm. C. Gorgas, Washington, D. C.	W. R. Steiner, 4 Trinity St., Hartford, Conn.	Washington, May, 1916.
Conf. of St. and Prov. Bds. of N. A.	A. G. Young, Augusta, Me	W. S. Rankin, Raleigh, N. C.	
Med. Association of the Southwest	J. D. Griffith, Kansas City, Mo..	Fred H. Clark, El Reno, Okla	Oklahoma City, 1915.
Mississippi Valley Medical Assn....	Hugh Cabot, Boston	Henry Enos Tuley, 705 S. 3d St., Louisville, Ky.	Lexington, Ky., 1915.
Missouri Valley, Med. Soc. of the....	Granville N. Ryan, Des Moines, Ia.	C. Wood Fassett, 224 S. 6th St., St. Joseph, Mo.	
National Assn. for Study of Pellagra	C.H.Lavinder,Savannah,U.S.P.H.S	J. W. Babcock, Columbia, S. C	1915.
Nat. Assn. for S. and P. of Tuber.	Geo. M. Kober, Washington, D. C.	Chas. J. Hatfield, 105 E. 22d St., New York...	
Nat. Assn. for Study of Epilepsy..	A. S. Priddy, Lynchburg, Va	Arthur L. Shaw, Sonyea, N. Y.	
Southern Medical Association	Oscar Dowling, Shreveport, La....	Seale Harris, Van Antwerp Bldg., Mobile, Ala.	Dallas, Tex., Nov. 8-11, '15.
Southern Surg. and Gyn. Assn....	Bacon Saunders, Ft. Worth, Tex.	W. D. Haggard, Jr., 148 8th Av. N., Nashville	Cincinnati, 1915.
Western Surgical Association	Jos. Rilus Eastman, Indianapolis	Arthur T. Mann, Donalson Bldg., Minneapolis	Des Moines, 1915.

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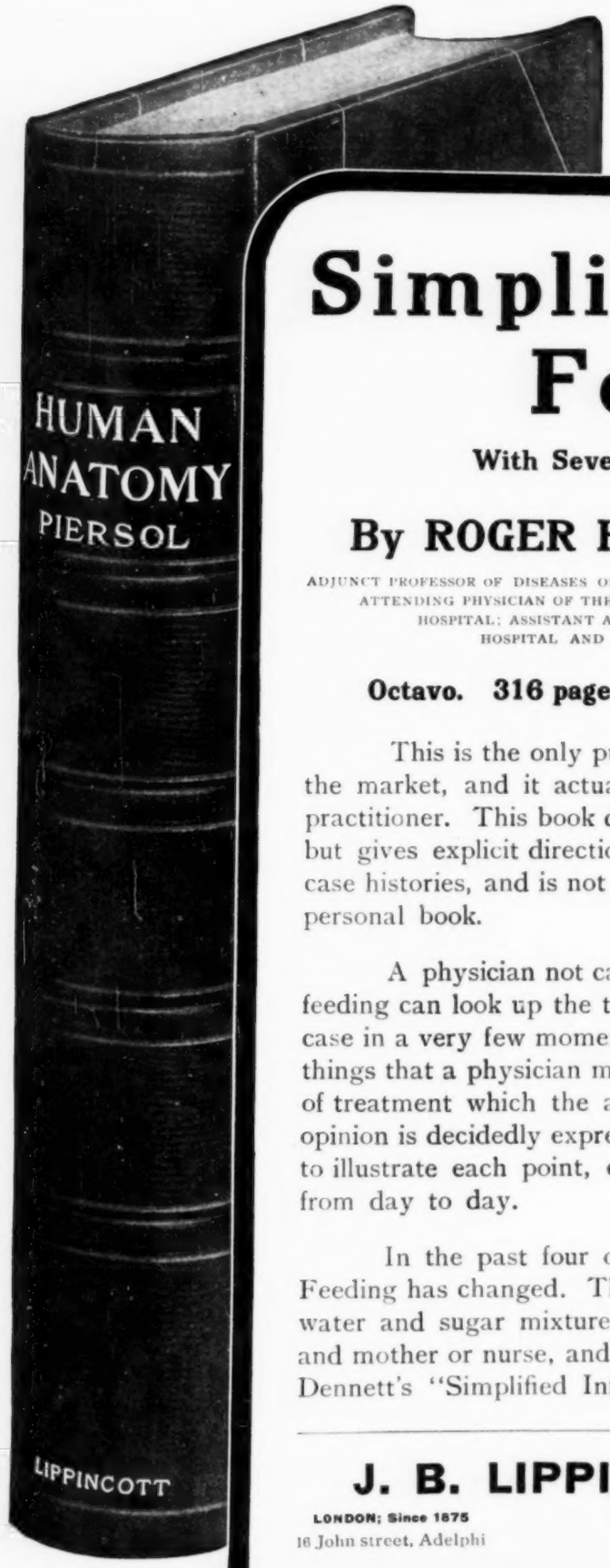

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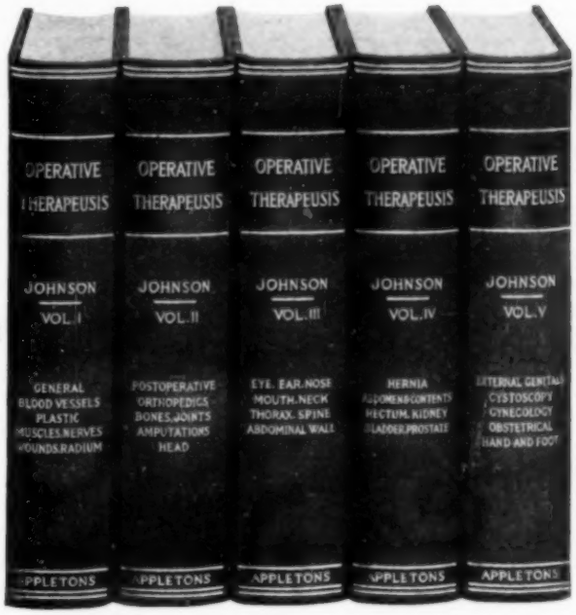
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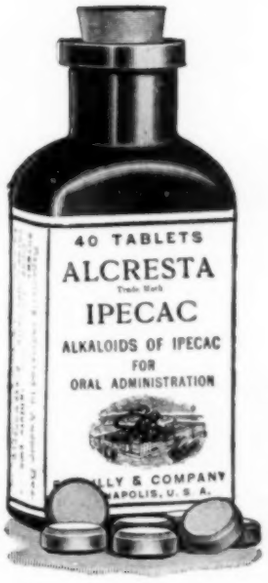

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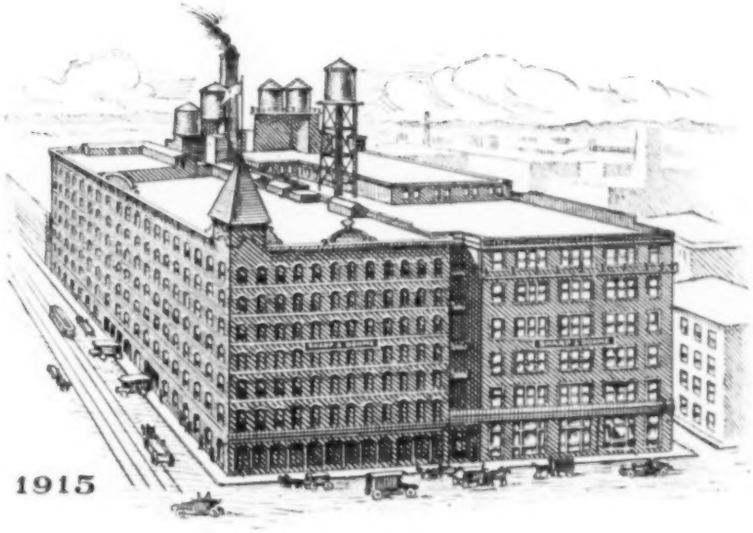
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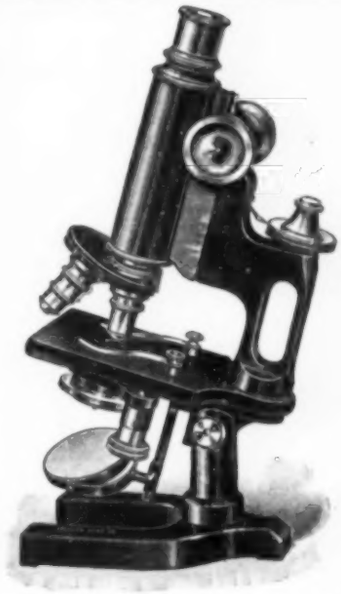

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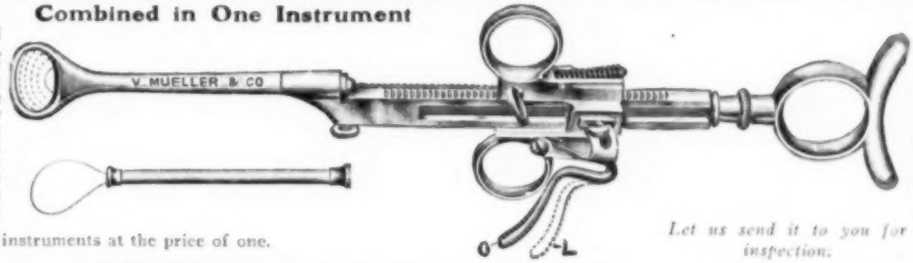

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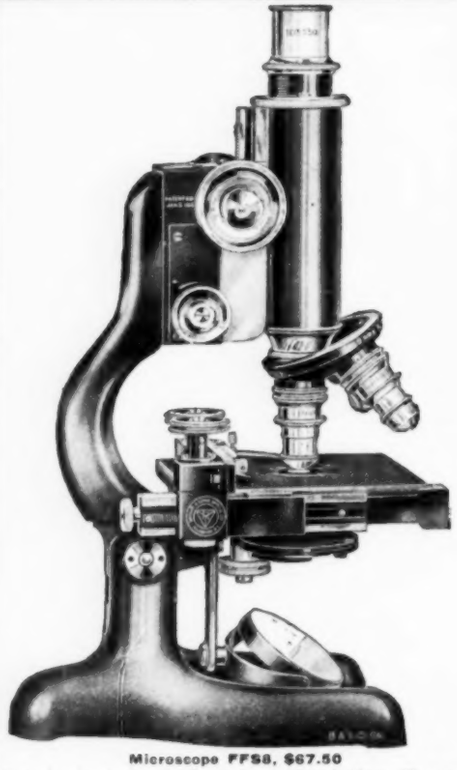

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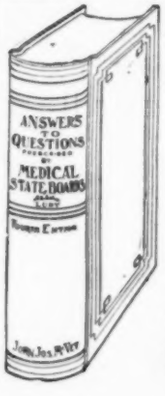

Answers to Questions
— PRESCRIBED BY —
Medical State Boards
BY
ROBERT B. LUDY, M.D.
Fourth edition, 8vo, 776 pages; price, $3.75 net, prepaid.
Only original state board book, not an imitator. Has real questions asked, with accurate answers by specialists.
JOHN JOS. McVEY, Publisher
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Advertisements under the following headings cost **$1.50 for 50 words or less,** additional words 3c each. This rate applies for each insertion.

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Assistant	Situation	Locations for Sanit.
Books	FOR SALE	FOR RENT
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Locum Tenens		

RESULTS are better when an advertisement receives several consecutive insertions, and to those who remit $6 ($6.25 if answers are to be sent through this office) for four insertions of a 50-word advertisement we will give, *free, two more insertions* provided the first four do not consummate a deal. Notice for free insertions must be received within two weeks from date of last insertion.

RESULTS VS. ECONOMY—DO NOT TRY TO economize at the expense of the effectiveness of your advertisement by omitting important and attractive features. In selling a practice, value of which runs into hundreds of dollars, it is surely unwise to run the chance of losing a prospective purchaser by not including every important fact and favorable item pertaining to the location and practice. Extra words over fifty cost 3 cents each.

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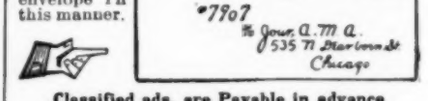
Carriages	Tr. Sch. for Nurses	Printers
Collections	Nurses Wanted	Salesmen

Miscellaneous Commercial Advts.

SPECIAL NOTE—A fee of 25c. is charged those advertisers who have answers sent % AMA. Letters sent in our care are forwarded promptly.

Frequently, we receive requests to this effect: "Please send me the address and particulars regarding ads. No.——, No.——, and No.——." We are not permitted by advertisers who have their mail sent % AMA to furnish inquirers information of any kind, hence when you wish to correspond with such an advertiser, address the envelope in this manner.



Classified ads. are Payable in advance
Rates for display ads. sent upon request
For current issue, ad. must reach us by 4:30 p. m. Monday.
Journal A.M.A., 535 N. Dearborn St. CHICAGO

N. B.—We exclude from our columns all known questionable ads. and appreciate notification from our readers relative to any misrepresentation.

ASSISTANTS WANTED

WANTED — EYE, EAR, NOSE AND throat physician; thoroughly competent, sober and reliable; salary $100 per month to start; city in Iowa; good future; send references, experience, training and photo. Add. 8379 B, % AMA.

WANTED—A YOUNG PHYSICIAN TO act as resident physician in Tubercular Sanatorium, near Los Angeles, Calif.; good opportunity for young man wishing to specialize on chest. Add. 8375 B, % AMA.

WANTED—UNMARRIED PHYSICIAN AS assistant in Nervous and Mental Sanatorium in the East; $600 a year and maintenance; must have had hospital experience and fairly well up in laboratory work; morals and good appearance a necessity. Add. 8377 B, % AMA.

WANTED—ASSISTANT; YOUNG WOMAN physician to assist an F. A. C. S. in clean eye, ear, nose and throat practice in small Illinois city; practice not excessive; the object being to do the best and most thorough work possible; give experience and salary expected. Add. 8284 B, % A.M.A.

WANTED — EYE, EAR, NOSE AND throat physician, thoroughly competent, sober and reliable; salary $1,200 and 25% on profits of medical and surgical work; reply with photograph. C. A. Hoffman Co., 814 Nicollet Ave., Minneapolis, Minn. B

(Continued on page 22)

The

Mental Appeal in Dietetics

The taste, flavor and appearance of food are more than mere esthetic considerations; they have an important influence on appetite and digestion. Moreover, it is essential that the food, through its variety, shall make an appeal to the mind. Through the use of a ***pure*** baking powder, many appetizing, nutritious and wholesome foods can be prepared from the most simple ingredients.

ROYAL
Baking Powder

will insure food tempting to the palate and possessing only healthful qualities. Royal Baking Powder contains no Alum or Phosphate of Lime. It is made from pure Cream of Tartar derived from ripe grapes, and is

Absolutely Pure

A M. A. ANNOUNCEMENT

(Continued from page 20)

ciation; for example: Guide to Current Medical Literature, American Medical Directory, Handbook of Therapy, Laws Regulating Practice, New and Nonofficial Remedies, Nostrums and Quackery, Pamphlets on Defense of Research, Great American Fraud, Propaganda for Reform in Proprietary Medicines, Pamphlets on Medical Fakes and Fakers.

ARCHIVES OF INTERNAL MEDICINE

Monthly, $4 a year; to JOURNAL subscribers, $3. Single copy, 50 cents.

AMERICAN JOURNAL OF DISEASES OF CHILDREN

Monthly, $3 a year; to JOURNAL subscribers, $2. Single copy, 30 cents.

GUIDE TO CURRENT MEDICAL LITERATURE

Semi-annual, 50 cents a copy, $1.00 a year. An index medicus of the world.

AMERICAN MEDICAL ASSOCIATION,
535 N. DEARBORN STREET, CHICAGO

Tonics and Sedatives

IT KEPT HIM BUSY

A reporter on a country paper had visited the court for a number of days in succession without raising a story, and he complained:

"What's the reason there is no crime stuff around here any more judge?"

"Kaint tell, bub, less'n th' constable is gittin' a leetle bit laxative," answered the justice.—*Argonaut.*

—o—

A PROPER CHRISTENING

"What's that you call your mule?"

"I call him 'Corporation,'" answered the old negro.

"How did you come to give him such a name?"

"E'm studyin' de animal and readin' de papers, boss. Dat mule gets mo' blame an' abuse dan anythin' else in de township, an' goes ahead havin' on his way jes' de same."—*National Monthly.*

—o—

BLOWING SOME

Two old Scotchmen were one day disputing as to who remembered the windier day.

"I mind it bein' sic a win'," said one, "that it took the craws three 'oors to flee hame frae the dominie's field, an' that's no mair than a mile."

"Hoot, mon!" the other replied, "I've seen it that windy that the craws had to walk hame!"—Pittsburgh *Chronicle-Telegraph.*

—o—

THE ROACH

Mr. Jones got up at night. After he had taken some six or seven steps he stubbed his toe on the baby carriage.

"D— Ford cars," he said, "they get in everywhere."—*Fun About Fords.*

—o—

AVOIDING THE TAILOR

"The other people on the block are sore on me," sighed the tailor. "Say I have killed business on this side of the street. It isn't my fault, though."

"What's wrong?"

"So many men owe me who cross over to the other side when they come to my block."—Kansas City *Journal.*

—o—

HE HAD ESTHETIC TASTES

The artist was painting—sunset, red, with blue streaks and green dots.

The old rustic, at a respectful distance, was watching.

"Ah," said the artist, looking up suddenly, "perhaps to you, too, Nature has opened her

(Continued on next page)

$YSTEM FOR THE DOCTOR

means money and time saved, more efficiency in the treatment of the patient and less drudgery for the physician.

THE HOLDEN SYSTEM

is simplicity itself and a recognized economical complete, uniform and reliable short-cut method for ACCOUNTS and CASE-RECORDS

Eleven years of success.

LET US SHOW YOU! WE CAN!

Address Box 351, Yonkers, N. Y.

Carbon Dioxide Ice

An effective therapeutic agent for removing **Moles and Warts, Papillomata, Epitheliomata, Angiomata, Lupus Vulgaris. All pigmentary, hairy congenital deformities of skin and many other dermatoses.**

Illustrated circular free on request.

AMERICAN CARBONIC MACHINERY CO.
1638 Otis Building · CHICAGO, ILL.

A STUBBORN FACT invites admiration, provided the fact rests on something that makes life easier and better.

IT IS A FACT that the **ALLISON** Tables and Cabinets for over 25 years have been the admitted standard by which all others are measured.

Write for our list No. 2, of special Prices on Tables, Chairs, Cabinets and Office Accessories.

W. D. ALLISON CO.
916 N. Alabama St. · Indianapolis, Ind.

SEND FOR CATALOGUE ILLUSTRATING OVER 150 SIZES AND STYLES OF

PHYSICIANS' BAGS and CASES

WESTERN LEATHER MFG. CO.
MAKERS
184 W. Lake St. Chicago

"AMBUMATIC" WASHABLE ABDOMINAL

SUPPORTERS

Patented. Made buckled or laced.

DO THE WORK "JUST RIGHT" ADJUSTABLE FOR "LIFT UP" OR "BINDER SUPPORT"

To any part of the abdomen. Adapted to any person, any condition requiring efficient, comfortable support.

Call or send to day for folder, order blanks and catalog.

We Are Experts in Corrective

ORTHOPEDIC APPLIANCES

ELASTIC STOCKINGS, TRUSSES, CORSETS, ETC.

Your correspondence solicited, given careful attention and full information. Phone Cent. 4623

ORDER THE AMBULATORY PNEUMATIC SPLINT

To secure greatest comfort, shortest period of confinement, best results and health for your

FRACTURES

of leg, knee, thigh, and hip patients. All dealers and direct from us. Wire order. State fracture, which limb, sex. Send for booklet, prices, etc. Recommend it.

Amb. Pneu. Splint Mfg. Co., 30 (A.) E. Randolph Street, Chicago

See page 20 for cost of classified and commercial announcement advertisements.

(Continued from page 20)

WANTED—A SINGLE MAN, RECENT graduate, registered in Michigan, to act as assistant and laboratory worker; salary $100 per month, and rooms with steam heat, electric light and bath; give reference, age, experience, when and where graduated, religious and fraternal connections; splendid opportunity for experience; modern mining town, up to date in every respect. Add. 8270 B, % A.M.A.

PHYSICIANS WANTED

WANTED—PHYSICIAN WHO IS ALSO A druggist, for location in South Dakota to start drug store and practice; building suitable for drug store and living rooms for family; so occupied for years and former owner retiring; place to move or start a drug store and practice; will sell building on very small payment; for particulars of deal, location, etc., address, Dr. E. Gomer Davies, 1000 Walnut St., Yankton, S. D. C

WANTED — EYE, EAR, NOSE AND throat physician to fill a vacancy caused by death; must be thoroughly competent. Add. Maywood Hospital, Sedalia, Mo. C

WANTED — EYE, EAR, NOSE AND throat specialist, or general practitioner, to take offices just being vacated by a specialist well established for many years, and now retiring, in a growing city of 50,000 population. The Geo. G. Newton Co., Superior, Wis. C

WANTED — EXCEPTIONAL OPPORTUnity for young woman physician to study x-ray work preparatory to taking position in the Woman's Hospital of Philadelphia. For details apply to Dr. A. M. Seabrook, Superintendent of the Woman's Hospital, 2137 N. College Ave., Philadelphia, Pa. C

WANTED—AN EXPERIENCED LABORAtory man; splendid opportunity for one capable of accurate work in the making of Wassermann, Abderhalden and Widal tests, who can examine blood, stomach content, urine, spinal fluids, etc., as well as report reliably on all kinds of tissue, can find a good opening in a live western city of 40,000 people, where he will be given the support of from 30 to 50 physicians in active practice and furnished with enough money to cover all overhead expense; none but thoroughly trained men need apply; write at once. Add. 8335 C, % AMA.

WANTED — AN EYE, EAR, NOSE AND throat man, competent to do the ordinary work, can learn of a good location in an Ohio Valley state; must be ethical; nothing to sell. Add. 8339 C, % AMA.

NURSES WANTED

WANTED—CAPABLE NURSE TO ASSIST doctor in his practice and small hospital; salary, $35 to $50 per month as per ability, with board and room; please state in first letter, age, height, weight, preliminary education, training, experience, salary expected, when could come; inclose references and photo. Odebolt Hospital, Odebolt, Iowa.

WANTED — GRADUATE NURSE FOR small hospital in small town Pacific Coast state; must be competent to assist in operating room and otherwise aid busy surgeon; salary $50 per month with board and room, no personal laundry; must accept immediately; give age, references, where trained and send photograph. Add. 8278 % A.M.A.

INTERNS WANTED

WANTED—RECENT GRADUATE WOMAN physician for a position as intern in large hospital for the insane; also want experienced graduate man pathologist. Add. 8376 D % AMA.

WANTED—TWO INTERNS—LODGING board and laundry furnished; $10 per month will be paid. Add. Secretary, Medical Staff, St. Luke's Hospital, St. Louis, Mo. D

WANTED—WOMAN INTERN AT BOEHNE Camp Tuberculosis Hospital; 30 beds, Evansville, Ind; salary $600. Apply to Dr. James Y. Welborn, Evansville, Ind. D

LOCATIONS WANTED

WANTED — IN ILLINOIS — LOCATION that yields not less than $3,000 yearly; size of town not important; give full particulars in first letter; proposition must bear close investigation; would like to succeed successful elderly man, retiring. Add. 8385 E, % AMA.

(Continued on next page)

TONICS AND SEDATIVES

(*Continued from preceding page*)

sky-pictures page by page? Have you seen the lambent flame of dawn leaping across the livid east; the red-stained, sulphurous islets floating in the lake of fire in the west; the ragged clouds at midnight, black as a raven's wing, blotting out the shuddering moon?"

"No," replied the rustic, shortly; "not since I signed the pledge."—*Tit-Bits.*

Books Received

Books received are acknowledged in this column, and such acknowledgment must be regarded as a sufficient return for the courtesy of the sender. Selections will be made for review in the interests of our readers and as space permits.

DIARRHEAL, INFLAMMATORY, OBSTRUCTIVE AND PARASITIC DISEASES OF THE GASTRO-INTESTINAL TRACT. By Samuel Goodwin Gant, M.D., LL.D., Professor of Diseases of the Colon, Sigmoid Flexure, Rectum and Anus at the New York Post-Graduate School and Hospital. Cloth. Price, $6 net. Pp. 604, with 181 illustrations. Philadelphia: W. B. Saunders Company, 1915.

ALVEOLODENTAL PYORRHEA. By Charles C. Bass, M.D., Professor of Experimental Medicine at the Tulane Medical College, and Foster M. Johns, M.D., Instructor in the Laboratories of Clinical Medicine at the Tulane Medical College. Cloth. Price, $2.50 net. Pp. 167, with 42 illustrations. Philadelphia: W. B. Saunders Company, 1915.

INDISPENSABLE ORTHOPEDICS. A Handbook for Practitioners. By F. Calot, Chief Surgeon to the Hôpital Rothschild. Translated from the Sixth French Edition by A. H. Robinson, M.D., M.R.C.S., and Louis Nicole. Two volumes. Cloth. Price, $5 per volume. Pp. 1175, with 1,260 illustrations. St. Louis: C. V. Mosby Company, 1915.

OPERATIVE GYNECOLOGY. By Harry Sturgeon Crossen, M.D., F.A.C.S., Associate in Gynecology, Washington University Medical School. Cloth. Price, $7.50. Pp. 670, with 770 illustrations. St. Louis: C. V. Mosby Company, 1915.

The Public Service

U. S. Public Health Service

Changes for the seven days ended June 16, 1915:

Blue, Rupert, surgeon-general, designated by the State Department as delegate on the part of the United States to the Pan-American Medical Congress, to be held at San Francisco, Calif., June 17-21, 1915.

Kerr, J. W., asst.-surgeon-general, designated by the State Department as delegate on the part of the United States to the Pan-American Medical Congress, to be held at San Francisco, Calif., June 17-21, 1915.

Irwin, Fairfax, senior surgeon, granted 12 days' additional leave of absence, from July 24, 1915.

Pettus, W. J., surgeon, granted 6 days' leave of absence on account of sickness, from June 6, 1915.

Magruder, G. M., surgeon, granted 7 days' leave of absence from June 23, 1915.

Young, G. B., surgeon, granted 1 month's leave of absence from June 28, 1915.

Gardner, C. H., surgeon, directed to proceed to Detroit, Mich., to arrive Monday morning, June 21, 1915, to serve as recorder of a board of commissioned officers for the examination of candidates for admission to the Service.

Foster, M. H., surgeon, granted 1 month's leave of absence from July 5, 1915.

King, W. W., surgeon, granted 9 days' leave of absence, on account of sickness, from May 23, 1915.

Fox, Carroll, surgeon, directed to proceed to Toledo, Ohio, to complete the investigations

(*Continued on next page*)

WASSERMANN TEST $5.00

(Including Noguchi Control Test)

Expert work and prompt reports assured

Our technique is accurate and reports perfectly dependable. We enjoy facilities and advantages which merit your preference. If you are practicing in the west, it will be to your advantage to send your specimens to our laboratories. Reports telegraphed without extra charge. Fee list and containers mailed on request.

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San Francisco, Cal. - Pacific Bldg. | Los Angeles, Cal. - Hollingsworth Bldg.
Oakland, Cal. - - Physicians Bldg. | Seattle, Wash. - - Green Bldg.

ILLINOIS TRAINING SCHOOL FOR NURSES

FOUNDED IN 1880

Offers an up-to-date course in theoretical instruction and practical training to women who wish to enter the nursing profession.

Favorable applicants must meet the requirements of good health, of age (19-35), and of good moral character, having had one year of High School or its educational equivalent.

The instruction covers a period of three years, practical instruction being obtained in Cook County Hospital and private hospitals.

The school catalogue and blanks will be sent on application to the Superintendent of Nurses,

Mary C. Wheeler, R.N., 509 Honore Street, Chicago, Illinois.

Let Us Fortify You With the Right Gloves

"Well-Nown" Gloves Afford You the Protection Necessary In Your Operations

A **Perfect** fit and always **Fresh** rubber they are absolutely **Guaranteed** as to **Wearing** quality and **Sterilization** or **money refunded.**

"Well-Nown" gloves are used by the most **Eminent** surgeons of the **Country** and **Leading** hospitals where Excellent Equipment is the first requisite.

SENT PREPAID ON RECEIPT OF PRICE (Foreign postage extra)

	2 pairs	6 pairs	1 doz. pairs
Medium Weight, smooth - - -	$1.00	$3.00	$5.00
Medium Weight Pebbled Non-Slip	1.20	3.60	5.75

Tissue Cots, assorted sizes, 3 doz. (no less) 80c

L. T. KINNEY & CO., 56 E. Randolph St., Chicago, Ill. Sizes 6 to 10. Mention size and style when ordering

MALIGNANT INFECTION

is only one of the

Hidden Dangers of Your Profession

You need the protection from disability and accidental death afforded by insurance in the

PHYSICIANS CASUALTY ASSOCIATION

of OMAHA, NEBRASKA

A mutual accident Association writing insurance at actual cost.

Send today for information about our policies

E. E. ELLIOTT, Sec.

304 City National Bank Building

OMAHA, NEB.

Stationery For Professional Men—Letterheads envelopes, etc., for physicians, druggists, dentists. Finest quality *Engravureprint* process at about one-half the price of ordinary printing. Portfolio of samples and price-list sent free upon request. Write for them *today!*

Eugene Smith Co., 151 Fox St., Aurora, Ill.

GRADUATE NURSES FURNISHED

We have nurses with advanced hospital experience located in every state in this country, wanting hospital positions. If you need a nurse in any department, write or wire; we will put you in touch with nurses promptly. No charges for this service.

AZNOE'S CENTRAL REGISTRY FOR NURSES

3644 Grand Boulevard, Chicago, Illinois.

OPTIC PROJECTION

By Simon Henry Gage, B.S. and Henry Phelps Gage, Ph.D.

Principles, installation and use of all forms of Projection Apparatus, including directions for showing refractive eye defects on the screen.

For a review of this work, see The Journal, Jan. 16, p. 258.

Library Buckram, 8vo., pp. 731, $3.00 Postpaid

16-page circular on request.

Comstock Publishing Company

124 Roberts Place ITHACA, N. Y.

PLEASE MENTION THE JOURNAL A. M. A. WHEN WRITING TO ADVERTISERS

(*Continued from preceding page*)

WANTED — EYE, EAR, NOSE AND throat practice or partnership, or would enter strictly first-class ethical firm of surgeon, internist, gynecologist, etc.; any large city, Chicago preferred; A+ graduate; over three years' active general practice, then three years' thorough course and degrees in above specialty in the best American and European institutions; considerable experience in hospital and practice; 32 years old; have worked hard; can deliver the goods; Protestant, teetotaler, Shriner; best American and European references on ability and character; every proposition must be absolutely clean and bona fide to receive consideration; write complete detail first letter; held sacredly confidential. Add. 8232 E, % AMA.

WANTED—PATHOLOGIST DESIRES LOcation; do you need some one in your community who can do Wassermanns, blood, sputum and bacteriological work, tissue diagnosis, etc.? am looking for good opening and will appreciate hearing from physicians. Add. Physician, 1221 Montgall Ave., Kansas City, Mo. E

WANTED — BY PHYSICIAN, AGED 34, married; graduate A+ school; four years' hospital, medical, surgical and private practice experience; also anesthesia; location in growing town, country, Virginia, North Carolina, Kentucky, West Virginia, Georgia; preferably salaried position with corporation; chance to build up outside practice; will consider assistantship with busy physician. Add. 8203 E, % AMA.

WANTED—BY PHYSICIAN — LOCATION, preferably Virginia, Maryland, North Carolina, Kentucky or Georgia; Graduate A 1 school; married, aged 30; three years' hospital and private practice; will consider salaried position with corporation, institutional work or assistantship to a busy physician; state particulars in first letter. Add. 8394 E, % AMA.

WANTED—TO BUY A GOOD PRACTICE in Nebraska, Kansas, Oklahoma, Colorado, Utah, in town 1,000 to 5,000; give distance to a hospital and competing towns and full information about your town—price of land, nationality and density of population, age of competitors, do any of them do surgery, particulars about your business. Add. 8369 E, % AMA.

WANTED — LOCATION BY GRADUATE of University of Illinois who has had extensive experience as practitioner; location in Indiana or Illinois within 100 miles of Chicago preferred; can make moderate investment in real estate or equipment if price is right; in answering give full particulars respecting monthly income, territory, nationality and competition. Add. 8381 E, % AMA.

(*Continued on next page*)

THE PUBLIC SERVICE

(*Continued from preceding page*)

of sanitary administration in that city; thence to proceed to Carson City, Nev., to conduct a study of public health organization and administration.

Korn, W. A., surgeon, leave of absence for one month from Jan. 6, 1915, revoked. Directed to assume charge of the San Francisco Quarantine Station, Angel Island, Calif., relieving Surgeon M. W. Glover.

Bahrenburg, L. P. H., surgeon, detailed to attend the Summer School for Health Officers, to be held at the University of Texas, Austin, Tex., June 16-17, 1915.

Holt, J. M., surgeon, leave of absence for 29 days from June 9, 1915, revoked.

Kolb, Lawrence, P. A. surgeon, detailed for duty at the Manhattan State Hospital, Ward's Island, N. Y., for the study of mental diseases, beginning July 1, 1915.

Watkins, J. A., asst.-surg., granted 2 months' leave of absence from July 5, 1915.

Slaughter, W. H., asst.-surg., directed to proceed to Annapolis, Md., for duty in connection with investigations of rural sanitation in Anne Arundel County.

Prather, D. J., asst.-surg., directed to proceed to Adel, Ia., for duty in connection with the investigation of rural sanitation in Dallas County.

Reimer, H. B. C., acting asst.-surg., directed to proceed to the Marine Hospital, Chelsea, Mass., for temporary duty during the absence of P. A. Surgeon G. L. Collins.

Slough, Charles, pharmacist, relieved from duty at the Immigration Station, Ellis Island, N. Y., and proceed to Gulf Quarantine Station, Biloxi, Miss., and report to the medical officer in charge for duty and assignment to quarters.

Stier, C., pharmacist, relieved from duty at the Gulf Quarantine Station and directed to proceed to Boston, Mass., and report to Surgeon S. B. Grubbs for duty.

Wilbert, M. I., technical assistant, directed to attend the meeting of the Pennsylvania Pharmaceutical Association, Forest Park, Pa., June 22-24, 1915.

Hommon, H. B., sanitary chemist, directed to proceed to Cincinnati, Ohio, to inaugurate the industrial waste studies carried on from that station.

Applewhite, C. C., field investigator, directed to proceed to Walker County, Alabama, for duty in connection with field investigations of rural sanitation.

Taylor, Quintard, field investigator, directed to proceed to Walker County, Ala., for duty in connection with field investigations of rural sanitation.

BOARDS CONVENED

Board of commissioned medical officers convened to meet at the Bureau, Monday, June 21, 1915, for the purpose of examining applicants for appointment as assistant surgeons in the Public Health Service. Detail for the board: Asst.-Surg.-Gen. W. G. Stimpson, chairman; Asst.-Surg.-Gen. L. E. Cofer, member; P. A. Surg. E. A. Sweet, recorder.

Board of commissioned medical officers convened to meet on Monday, June 21, 1915, at 10 a. m., for the purpose of making physical examinations and conducting the mental examinations of candidates for appointment as assistant surgeons in the Public Health Service, as follows:

Marine Hospital, Detroit, detail for the board: Sr. Surg. H. W. Austin, chairman; Surg. C. H. Gardner, recorder.

Immigration Station, Ellis Island, N. Y., detail for the board: Surg. L. L. Williams, chairman; Surg. C. H. Lavinder, recorder.

Marine Hospital, San Francisco, detail for the board: Surg. R. M. Woodward, chairman; Asst. Surg. W. M. Jones, recorder.

Marine Hospital, Chicago, detail for the board: Surg. J. O. Cobb, chairman; Asst. Surg. C. L. Williams, recorder.

Marine Hospital, St. Louis, Mo., detail for the board: Surg. M. J. White, chairman; Asst. Surg. H. C. Cody, recorder.

Marine Hospital, New Orleans, detail for the board: Surg. R. H. von Ezdorf, chairman; Surg. R. A. Kearny, recorder.

Teeth Cutting Made Easy

Good teeth mean good health and a good body

BABY EDUCATOR

Is a Food Teething Ring made from pulverized honey-sweetened cereals baked so hard that just a little is eaten at a time as it becomes moistened by the saliva.

The Baby Educator Food Ring pacifies the teething baby and at the same time develops the teeth and jaws. Better than tasteless and foodless rubber rings.

EDUCATOR GRACKERS

Doctor, may we send you free samples? Your name on a post card will do.

Johnson Educator Food Co.
30 Batterymarch St., Boston.

$2 A MONTH FREE TRIAL

Late Style Visibles. Every modern convenience. Back Spacer Tabulator—Two Color Ribbon—Automatic ribbon Reverse, etc. **Bargain Prices.** Perfect machines with complete equipment, every extra. Guaranteed against defect. **Free** circular describes special FIVE DAYS' TRIAL OFFER. Address

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LUX LEGS ARMS BRACES

BRACES FOR ALL KINDS OF DEFORMITIES, MADE TO ORDER.

Artificial legs, arms, arch supports, abdominal supports, trusses, wheel chairs and crutches.

RAY TRAUTMAN, Minneapolis
522 Medical Block Nic. 4289

Sold On Easy Terms

Runs on Alcohol

at cost of less than ½ cent an hour anywhere without electricity, springs or batteries. Superb construction. 12-inch blades. Adjustable roller bearing. Reliable. A proved comfort. Prompt delivery. **Keep Cool**

Write for price and free circular
LAKE BREEZE MOTOR
116 N. Jefferson St., CHICAGO

The ARGO LYING-IN HOSPITAL

A private maternity home, under the management of the Argo Hospital, affording every kindness and protection to its patients and their infants. Graduate nurses and attending physicians. Rates, $10 to $15 per week. *Correspondence solicited from Physicians.*

Address, Rose Massoth, R.N., Supt.
Phone Summit 178-M ARGO, ILL. Cook County

POMPEIAN OLIVE OIL

ALWAYS FRESH
PURE-SWEET-WHOLESOME

(*Continued from preceding page*)

WANTED—BY A PHYSICIAN WITH 20 years' experience in general practice; graduate of Class A college, with hospital and post-graduate experience; a good location for practice, or partnership with a busy practitioner; can furnish best of references; Ohio, Iowa or Colorado preferred. Add. 8393 E, % AMA.

WANTED—UNOPPOSED LOCATION IN Illinois; state terms, amount of annual collections, fees, nationality predominating, distance to competition, size of town, character of country; or I will pay $50 to anyone pointing out a satisfactory location with little competition. Add. 8384 E, % AMA.

WANTED — LOCATION IN OHIO, OR partnership, by physician, aged 39, of 12 years' successful general practice, in town of four or five thousand or more; graduate of A+ school; best of references given; owing to recent financial loss, must be paying from the start. Add. 8366 E, % AMA.

LOCUM TENENS WANTED

WANTED—LOCUM TENENS FROM JULY 10 to JULY 24. Camp practice; salary. Add. Box 9, Walville, Wash. F

WANTED—AT ONCE—LOCUM TENENS with chances of making permanent deal; North Central Wisconsin; population, 1,200; one easy competitor; must be sober, well recommended; no cigarettes or drug addict wanted; should have own auto. Add. 8389 F, % AMA.

PARTNERS WANTED

WANTED—SOUTH CENTRAL WISCONsin; experienced German physician for partner, with view to becoming successor; village and country practice in rich agricultural community; state age, experience and give references in first letter; small amount of capital required. Add. 8386 G, % AMA.

WANTED — SURGEON OF NATIONAL reputation planning gradually to retire from practice, wants junior partner; opportunity for ambitious, capable and energetic younger surgeon, wishing to establish future in large city; applicant must have highest references as to character and ability; also sufficient capital to eventually take up part of interest in well-established and well-paying hospital. Add. 8327 G, % AMA.

WANTED—A RECENT GRADUATE WHO is interested in surgery and who will be willing to associate himself with a general practitioner in Minneapolis. Must be American, of good education, address and habits. Prefer one who can invest reasonable amount for equipment; very attractive offer on cooperative plan. Add. 8363 G, % AMA.

PARTNERSHIP WANTED

WANTED—TO BUY A PARTNERSHIP INterest with a surgeon who owns his own hospital in a good growing town in the west; Washington or Idaho preferred; 17 years in general practice; habits excellent. Add. 8324 H, % AMA.

WANTED — BY A WOMAN PHYSICIAN with a broad training and with money to invest, a part interest in a hospital for general and surgical work; best of credentials can be furnished of work done in this country and in Europe. Add. 8311 H, % A. M. A.

WANTED — PARTNERSHIP — A PHYSIcian who has a large practice in medicine and surgery who is contemplating, either by reason of age, ill-health or over-work, taking a partner; I am open for engagement at any time; ethical, honorable and sober; had 20 years' experience in medicine and surgery; 45 years of age; graduate of Eastern school; married; no family; will work on salary until convinced I am right; will buy part or all on retiring for good. Add. 8362 H, % AMA.

SITUATIONS WANTED

WANTED—A HIGH-GRADE DETAIL MAN of 18 years' experience in introducing specialties to the profession, who is capable of planning as well as executing campaigns of introduction, desires to correspond with any reputable firm wishing to avail themselves of A1 detail service, regarding which satisfactory proof and references can be furnished; his connection as the Chicago representative for the past 8 years of a well-known eastern firm will cease July 1. Add. 8337 I, % AMA.

(*Continued on next page*)

WANTED—SITUATION—TRAINED G. U. man will consider partnership or salaried arrangement; experienced in modern methods and can handle patients; assisted G. U. specialist who possesses national reputation; graduate A-plus school; general hospital and institutional experience; 28 years old; will go anywhere. Add. 8392 I, % AMA.

WANTED—ASSISTANTSHIP WITH BUSY practitioner or institution; two years general practice; nine months assistant in state institution; special training obstetrics; American, aged 30, single, Christian unaffiliated, teetotaler; best references; knowledge French; licensed Illinois, Maine; minimum salary $75 month with board, room, laundry. Add. 8391 I, % AMA.

WANTED — POSITION DESIRED BY bright young lady who desires to learn the drug business and after reasonable experience to invest cash and buy half interest if mutually agreeable; retail store experience but not in drug line; unmarried; 28 years old; good references; Catholic. Add. 653, Care F. V. Kniest, Medical Broker, Omaha, Neb. I

WANTED — SALARIED POSITION AS assistant or partner, or contract practice, by young man, graduate Class A school; familiar with laboratory work; references furnished; also registered pharmacist; write me and I will state particulars in detail. Add. 8378 I, % AMA.

WANTED—ASSISTANTSHIP WITH BUSY physician, surgeon or in hospital at once; single, aged 26; graduate Class A school, 1913; 18 months' general hospital training and 6 months' general practice; references furnished; California and Missouri license; state full particulars and salary in first letter. Add. 8354 I, % AMA.

WANTED—BY WOMAN PHYSICIAN—POsition as assistant in institution; experience from large state hospitals for insane and epileptics, with charge of acute service, hydrotherapy, etc.; experience from private sanitarium for nervous diseases; experience as superintendent of general hospital and training school; capacity 30 beds for three years. Add. 8216 I, % AMA.

WANTED—YOUNG MAN, AGED 23, SINgle, desires a position as assistant to a busy practitioner or take charge of small practice for the three summer months. Will be a senior next year in a Class A school; expect small salary and prefer East Tennessee if obtainable. Add. C. A. Frazier, Knoxville, Tenn. I

WANTED — A POSITION, INSTITUtional or assistant, leading to a partnership and salaried to safeguard a family, by an experienced physician and surgeon; 43 years old; seeking mild southern or western climate if possible; had special training and many years of hospital work along lines of abdominal surgery; best references. Add. 8318 I, % AMA.

WANTED—BY EXPERIENCED PATHOLOgist, bacteriologist and clinical miscroscopist position with institution, medical school or with a number of physicians and surgeons; have had 3 years' experience in general pathological and bacteriological work, clinical miscroscopy, serology, etc.; also teaching experience in most of these branches and 3 years in the practice of medicine; graduated in medicine in 1909; can furnish the best of reference. Add. 8265 I, % A.M.A.

WANTED—POSITION AS ASSISTANT TO obstetrician and gynecologist or surgeon; graduate A+ school; 2 years' general practice; 1 year general hospital training; single, aged 28; speak German; best references furnished as to morals and ability. Add. 8353 I, % AMA.

WANTED — LOCUM TENENS WORK — Physician, aged 32, graduate of Class A school; 2 years' hospital experience and 5 years in general practice; desires position as locum tenens; licensed in West Virginia and Indiana; references furnished. Add. 8397 I, % AMA.

WANTED—POSITION BY PHYSICIAN—Aged 34; married; no children; speaks English only; graduate '07 and '15 Class A2 school; 8 years' general practice; can do laboratory work; good reference furnished; habits good; prefer assistantship in tuberculous sanatorium in western Texas, New Mexico or Colorado; or would take a good contract practice; give full particulars in first letter; available June 10. Add. 8159 I, % AMA.

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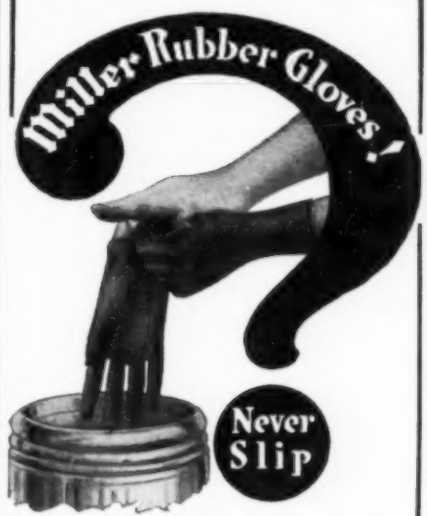

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Miller ice bags, water bottles, syringes, surgeon's caps, obstetrical gloves, household gloves, seamless finger cots, tubing, etc.

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(Continued from preceding page)

NURSES LOCATION WANTED

WANTED—POSITION AS HOSPITAL SUperintendent, by graduate registered nurse; nine years' experience as superintendent; graduate of a general hospital; three years' training; college education; experienced druggist and assistant in operating room; best of credentials as to character and ability. Add. 8373, % AMA.

APPARATUS, ETC., FOR SALE

FOR SALE—X-RAY OUTFIT, JUMBO coil, 16-inch, lead screen, ten good tubes (two new tungsten), lead glass shield, tube stand, etc., etc.; capable of heaviest and most rapid work; exchange for car, Ford preferred, or sell $175 cash. Dr. Herring, New Hamburg, N. Y. K

FOR SALE—SCHEIDEL-WESTERN RADIographic Special Coil outfit complete with compression diaphragm tube stand and table, all ready for use; cheap. National Physicians' Exchange, 30 E. Randolph St., Chicago, Ill. K

FOR SALE—MICROSCOPE COMPLETE—Made by Queen and Company; oil immersion lens included; everything in first class condition; will ship by express subject to inspection; price, $30. A. W. Skitton, M.D., Furnace Run, Pa. K

FOR SALE — SCHEIDEL-WESTERN 12 K. W. interrupterless apparatus complete with lead protective shield for 220 volt, 60 cycle A. C. in perfect condition, $500; 1 16-inch Scheidel-Western radiographic special coil outfit for A. C., $250; 1 20-inch Scheidel-Western radiographic coil outfit for A. C., $175. For further details write to the Wm. Meyer Co., 817 W. Washington Blvd., Chicago, Ill.

FOR SALE—CYSTOSCOPE, NITZE COMbination double catheterizing and examining; Loewenstein latest model Zeiss lens system, perfect, $40; urethroscope, Goldschmidt combination anterior posterior, Loewenstein latest model Zeiss lens, perfect, $45; Allison pynchon cabinet, bevel glass back and top, cost $97, sell for $30; perfect. Estate, % Dr. Michel, 15 Central Park West, New York City. K

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BOOKS WANTED AND FOR SALE

FOR SALE—MEDICAL BOOKS, A LARGE selection, new and old, A. M. A. Journals 1906 to 1915, not all; a Leitz microscope, a haemoglobinometer; a faradic and galvanic battery and attachments. Add. 8401 M, % AMA.

WANTED—JANUARY, MARCH AND NOvember, 1914, *American Journal of Diseases of Children.* We will pay 50 cents each for January and March issues, and 25 cents each for November issues, returned in good condition. Add. Amer. Med. Assn., 535 N. Dearborn St., Chicago. M

PRACTICES FOR SALE

FOR SALE—CALIFORNIA—$3,600 PRACtice; growing town, San Joaquin Valley; thickly settled dairying and fruit section; nine-room electric lighted house, garage; four-bed hospital with operating room; good opportunity; legitimate reasons for selling; price, $6,000, at least half cash; furniture and equipment optional. Add. 8303 N, % A. M. A.

FOR SALE—COLORADO—PRACTICE AND drug store in one of the richest agricultural regions in the state; good fees and collections; no competition; $2,500 to $3,000 yearly; good roads; money-maker from the start; best of reasons for selling; $750 cash; this adv. appears but once. Add. 8388 N, % AMA.

FOR SALE—COLORADO—IN GOOD BUSIness town of 1,500; good school, churches; electric lights and waterworks; unopposed and contract practice of $4,000 cash; all transferable; contracts $2,500; want $1,500 cash; this includes $500 worth necessary personal property; must leave by July 1; don't answer unless you mean business. Add. Box 622, Canon City, Colo. N

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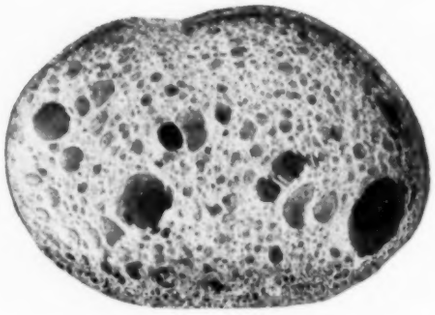

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FOR SALE — EASTERN COLORADO — $3,000 practice; $1,800 for 6-room house and three lots, terms on part; county seat; county high school; one competitor; nearest outside competition 10 and 25 miles; good roads; appointments; wish to specialize; send stamp if you mean business. Add. 8301 N, % A. M. A.

FOR SALE—CENTRAL ILLINOIS—CASH practice of $3,000; in rich farming community, and town of 750; collections 95%; German Lutheran, Catholic and Protestant people; competition congenial; Catholic young physician here since Jan. 1st; location, complete office equipment and furniture, large stock of drugs, automobile, storm buggy, price $1,800. Add. 8277 N, % A.M.A.

FOR SALE—NORTHERN ILLINOIS—ESTABLISHED practice for five years, averaging from $4,000 to $7,000 yearly; in town 650 inhabitants; rich farming community; collections, 90 per cent.; competition congenial; ten miles from two hospitals; eight-room house fitted for office, electric lighted; two lots, large barn and garage, good garden and chicken run; practice free to purchaser of property at $5,000, part cash, balance on easy terms; reason for leaving made known in correspondence; don't answer unless interested, as the proposition is a bargain to an energetic, able practitioner. Add. 8382 N, % AMA.

FOR SALE—CENTRAL ILLINOIS—CASH practice of $2,500 in rich farming community and town of 1,400 to purchaser of my residence, 2½ lots, new barn; complete office equipment including large stock of drugs and all furniture including safe included in price; $4,000 with terms if taken at once; reason for selling, going to larger place. Add. 8164 N, % A. M. A.

FOR SALE—ILLINOIS—GENERAL PRACtice in manufacturing town of 18,000; 90 miles S. W. of Chicago, in fine agricultural community; average collections, $200 monthly; reason for leaving, ill health; will show books and introduce; excellent office location; price exceptionally low to make a quick sale. Add. 8370 N, % AMA.

FOR SALE—ILLINOIS—$4,500 PRACTICE; suburb of Chicago; a real opening and an ideal place to live; population 5,000; fine schools and college; paved streets and macadam roads; can transfer some appointments; practice and introduction for invoice price of office fixtures and drug stock amounting to about $700. Add. 8355 N, % AMA.

FOR SALE—CENTRAL ILLINOIS—$3,400 country practice; established 10 years; village of 600; American community; for about value of office fixtures; unless you have $500 and are a clean honorable man, do not investigate this; reason for selling given if wanted; this proposition is absolutely sound. Add. 8336 N, % AMA.

FOR SALE — NORTHERN ILLINOIS— Railroad town of 900 inhabitants; a $4,500 practice; located in richest part of corn belt; land $300 per acre; distance to other towns 9, 13, 9, 12; opposition just right; want young or middle aged married man, Protestant, who is good mixer, willing to work, can come at once and has $500 cash; no real estate; rent, office $5, house $10; will introduce. Add. 8340 N, % AMA.

FOR SALE—EASTERN IOWA—GROWING town on railroad; only doctor; three churches, good schools, fine roads; very rich farming community; collections 100 per cent.; practice established 35 years; nearest doctor 8 miles; yearly practice $4,000; surgeon could do $5,500; new 7-room bungalow, garage, etc.; new 2-room office addition; large stock drugs; office furniture; insurance and county poor contracts; going to city; price, $4,000 cash. Add. 8350 N, % AMA.

FOR SALE — NORTHEASTERN IOWA — $3,500 or more unopposed practice in good business town of 350; fine farming; railroad; electric lights; large territory; collections first class; $500 buys large stock of drugs, static machine and office fixtures; good opportunity. Add. 8383 N, % AMA.

FOR SALE — CENTRAL IOWA — $3,000 practice; established 10 years; population 1,000, Americans and German-Americans; electric lights and water works; large territory; rich farmers; good roads; main line railway; railway surgeonship; good opening for surgeon; none for 16 miles; competition moderate; collections 98%; drugs, equipment and office furniture and introduction, $800; taking hospital postgraduate. Add. 8312 N, % A.M.A.

(*Continued on next page*)

FOR SALE—NORTH CENTRAL IOWA—$3,000 unopposed practice in rich farming section; collections 98 per cent.; good roads; fine people; competition 8, 8, 12 and 16 miles away and easy; good stock drugs, office furniture and good will, $400; practice can be doubled by right man with surgery. Add. 8185 N, % AMA.

FOR SALE—N. W. IOWA—$6,000 PRACtice to purchaser of my $7,000 office and residence in splendid farming community; town of 1,200; large territory, 10, 14, 18 miles; fees and collections good; electric light, water, sewer, hospital; taking up eye work. Add. 8347 N, % AMA.

FOR SALE — KANSAS — $3,000 UNOPposed general practice in town of 300; railroad; good collections; good roads; wide territory; will turn everything over to successor for price of equipment and drugs, auto and library optional; $500 will handle; if you have the cash and can come at once answer. Add. 8300 N, % AMA.

FOR SALE — SOUTHEAST KANSAS — Good general practice; town of 800 population; splendid farming country, fine roads; four churches; good high school; two railroads; one competitor, other competition 9½, 10, 12 miles; good reason for selling; office fixtures, drugs and introduction included; residence and office building optional. Add. 8400 N, % AMA.

FOR SALE—KANSAS—$4,000 PRACTICE in good business, home and college city of 50,000, to purchaser of my office equipment and modern 8-room residence, situated in choice residence district; terms if desired; or I will give introduction with purchase of office equipment at invoice (about $500) only; investigate. Add. 8326 N, % AMA.

FOR SALE—SOUTHERN KANSAS—GOOD location in town of 10,000; part contract practice; this alone will pay back money invested in one year; complete office and clinical laboratory equipment; price reasonable; excellent opportunity for the right man. For further particulars add. 8332 N, % AMA.

FOR SALE—MAINE—SPLENDID PRACtice; established 17 years; in beautiful village; practice runs $2,500 to $2,900; good people, schools, churches, roads, fees, collections; beautiful modern house, 12 rooms, steam heat, open plumbing; stable; several acres land; worth $8,000; sell $4,000, $1,000 cash, balance terms; thorough introduction; competition light. Add. 8399 N, % AMA.

FOR SALE — MASSACHUSETTS — PRACtice in exclusive Boston suburb; collections average $3,000 last twenty years; will sell house furnishings, lease on house and good will for $1,500 cash; detailed description on application; don't write unless you can pay cash and mean business. Add. 8361 N, % AMA.

FOR SALE—MASSACHUSETTS — GENeral practice with unopposed dermatological and G.-U. practice $8,000 to $10,000 per year; books, instruments, drugs, latest x-ray outfit and accessories, office furniture, etc., with or without real estate in city of over 115,000; exceptional opportunity. Add. 8352 N, % AMA.

FOR SALE — MICHIGAN — $3,400 CASH practice in one of best towns of 700 in state; office fixtures and furniture with large stock of drugs; am leaving state; price, $750. Add. 8395 N, % AMA.

FOR SALE—MICHIGAN—THE EYE, EAR, nose and throat practice with extensive office equipment recently purchased by Dr. Edward M. Hamaker and which he was prevented from taking over on account of his sudden death; an unusually desirable location in a good Michigan city. Add. Dr. W. D. Hamaker, Meadville, Pa. N

FOR SALE — MICHIGAN — UNOPPOSED $3,000 practice; collections, 99 per cent.; inland town of 375, among thrifty people and fine farms; good roads year round; drugs, office equipment, buggy, harness and cutter for $300; terms if desired; leaving state for partnership. Add. 8398 N, % AMA.

FOR SALE — MICHIGAN—PHYSICIAN'S country practice; good town; fine farming country; good fees and no cutting; large territory, fine class of people; business this year to May 1, $1,100; public school on university list; good hunting and fishing; price less than invoice; give immediate possession. Add. 8131 N, % AMA.

(Continued on next page)

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No. 21 6-gallon "	1.50	No. 23 10-gallon "	2.00

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FOR SALE — CENTRAL MINNESOTA— Splendid unopposed $7,000 hospital and general practice free to the purchaser of my 12-bed modern private hospital; $17,300 and equipment (hospital, office and household), $6,500; all under one roof; collections 98 per cent.; in a growing town; rich farming territory and beautiful lakes; a summer resort; half cash; balance terms. Add. 8333 N, % AMA.

FOR SALE—MISSISSIPPI — EYE, EAR, nose and throat practice; town 12,000; purchaser will have referred all case in his line from practice of three physicians, as well as those admitted to private sanatorium of 35 beds. Add. C. T. Chamberlain, M.D., Natchez, Miss. N

FOR SALE — NORTHEAST MISSOURI— Practice $3,000 per year in railroad town of 500; electric lights; four churches; good school; good roads; rich farming community; $500 cash for office equipment, drugs and location; excellent opportunity. Add. 8194 N, % AMA.

FOR SALE — NORTHEAST MISSOURI— Will turn to purchaser of my office outfit splendid unopposed practice in up-to-date town of 300; high school, electric lights; auto and property if wanted, with or without drug store; must sell; snap for some one; no triflers. Add. 8207 N, % AMA.

FOR SALE—NEW JERSEY—PHYSICIAN'S home and practice in up-to-date town; over 4,000 inhabitants; established 23 years; retiring on account of ill health; house modern and centrally located. Add. 8325 N, % AMA.

FOR SALE—EASTERN NEBRASKA—UNopposed general practice in good town on main line railroad; fine agricultural district; good collections; Protestant community; twelve grade schools; successor can make $2,500 first year without surgery; price, $800 for location, drugs and office equipment. Answer if have cash and can take charge inside two months. Add. 8396 N, % AMA.

FOR SALE—NEBRASKA—EXCEPTIONAL opening available account of death; extensive eye, ear, nose and throat practice; consultation and operative work; modern city 8,000 population; thrifty surrounding farming territory; complete equipment for special practice; cooperation of established surgeon; will sell reasonable; easy terms. Full particulars on request to Mrs. Julia A. Blanchard, Kearney, Neb. N

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The E. Z. Self-Cementing, Self-Vulcanizing Glove Patch

Saves hours of time and distasteful drudgery to those who have torn or punctured rubber gloves to mend. Best of all, saves money!

Takes only 60 seconds to apply, and through invaluable E. Z. process actually vulcanizes to the glove while sterilizing, and each successive boiling serves to make it more integral.

Non-poisonous and non-infecting. Always a permanent patch. So easy, so sure, so clean!

Trial envelope containing 12 E. Z. Patches, with full directions, for 25c. Hospital size, 100 patches for $1.00. Sample on request.

The E. Z. Patch Co.

AKRON, OHIO

FOR SALE—NEBRASKA—$2,000 TO $2,500 practice (which could be increased to $4,000 to $5,000 by one doing surgery) in village of 1,800; county seat; rich farming country; railroad appointments and city and county physician; will sell office practice and a few drugs for $500; the office and drugs being practically worth this amount. Add. Box 64, Albion, Neb.

FOR SALE—S. E. NEBRASKA — UNOPposed $6,000 practice; splendid farming section; good roads, schools, Protestant churches; here 8 years; made enough to retire; building equipment $4,000; one-half cash; drug store for self or friend; nets $3,000 annually. Add. 8172 N, % AMA.

FOR SALE — EASTERN NEW YORK — Schoharie County; fully equipped office, furniture, library, instruments, drugs, violet ray, hot air apparatus, everything to do business; population, 3,000; established practice; make $4,000 first year; excellent surgical opportunity; fifty miles from hospital; no real estate; if you want to buy a good practice in a good place this is worth while; will introduce and show you particulars upon request; price, $2,800. Add. 8390 N, % AMA.

FOR SALE — NEW YORK — SPLENDID practice. A physician, willing to work and desirous of locating in a Hudson River District, within 75 miles of New York, in consideration of the purchase of the deceased physician's residence, will find a life practice assured and unusual opportunities afforded by communicating with Mrs. A. T. Fink, Arlington, R. F. D., Dutchess Co., New York.

FOR SALE—NEW YORK — $8,000 PRACtice, largely surgical, 40 miles from New York City; visiting surgeon general hospital; do all major surgery in private hospital; can transfer appointments to capable man; $5,000 cash for quick turn; investigate; large equipment optional; will easily double in five years; reason, health. Add. 8351 N, % AMA.

FOR SALE — NEW YORK — PROPERTY and practice; property comprising house, barn, two acres of land with fruit; unopposed practice in central part of state; established seven years; $4,300 last year; village of 600; electric lights, macadam roads; intend to specialize; price $3,000, $1,200 cash, remainder easy terms. Add. 8380 N, % AMA.

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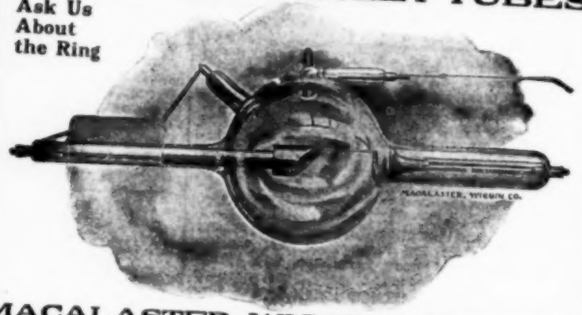

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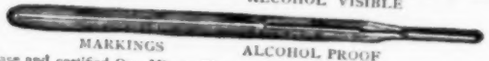

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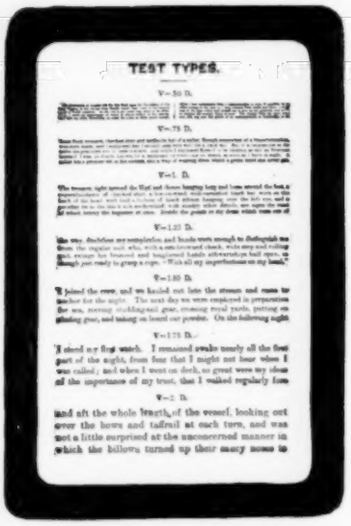

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Address The Secretary of the College of Medicine, 307 Orange St., Syracuse, N. Y.

College of Physicians and Surgeons of Baltimore
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Admission requirements—one year of college work in Biology, Chemistry, Physics and one modern language, in addition to 15 units of High School work. The college year may be taken as a pre-medical course at the College of Physicians and Surgeons by those students who have absolved the four year high school requirement. The clinical facilities in Medicine, Surgery and Obstetrics are unusually good. The Laboratories are well equipped and the technical training is thorough. THE COLLEGE OF PHYSICIANS AND SURGEONS HAS NOT MERGED WITH ANY OTHER MEDICAL SCHOOL AND NO MERGER IS CONTEMPLATED. For catalogue or information address.

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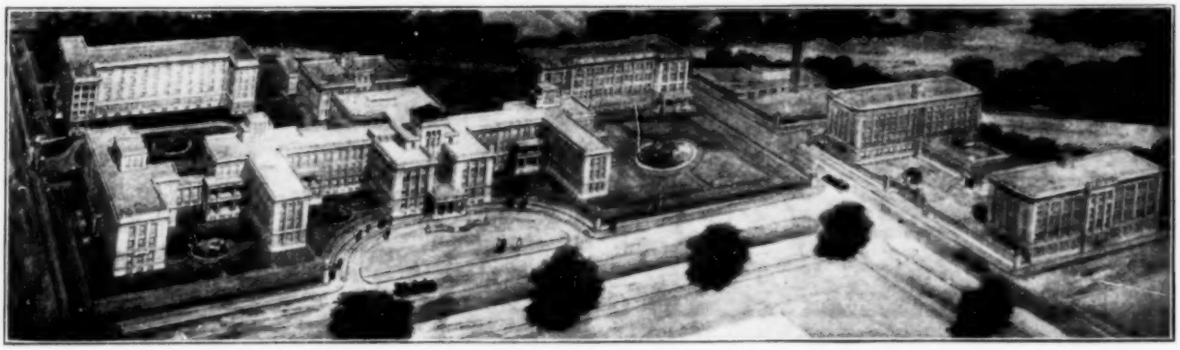

Requirements for Admission Candidates for entrance are required to have completed at least two full years of college work which must include English, German, and instruction with laboratory work in Physics, Chemistry and Biology.

Instruction Instruction begins on the fourth Thursday in September and ends on the second Thursday in June. Clinical instruction is given in the Barnes Hospital and the St. Louis Children's Hospital, affiliated with the medical school, the St. Louis Mullanphy Hospital, and in the dispensaries connected with these institutions.

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Tuition: The charge for tuition is $160.00 a year and $5.00 for matriculation. There are no extra fees except for rental of microscopes and laboratory breakage.

The academic year begins Sept. 27, 1915. All inquiries and other communications should be addressed to

THOMAS ORDWAY, M.D., Dean, Albany Medical College, ALBANY, N. Y.

NEW YORK UNIVERSITY

MEDICAL DEPARTMENT

The University and Bellevue Hospital Medical College

Session 1915-1916 begins Wednesday, September 22, 1915

The requirements for admission to the University and Bellevue Hospital Medical College include one year of collegiate work in addition to graduation from an approved four-year high school course. It is required that this year of college work include instruction in Physics, Chemistry, and Biology and German or French. To meet this requirement, the Collegiate Division offers the following Medical Preparatory Courses:

1. Course extending from September 22, 1915, to June, 1916.
2. Course extending from February 1, 1916, to September, 1916. The completion of either course admits to the medical school.

The requirement for admission to the Medical Preparatory Course is any one of the following:

(1) A diploma of graduation from a four-year high school course recognized by the Regents of the State of New York. (2) A certificate of the College Entrance Examination Board covering fifteen units of Secondary School Subjects. (3) Entrance examinations of the University College covering fifteen units of Secondary School Subjects. (4) A certificate of admission to the freshman class of a recognized college. For bulletin or urther information address **DR. SAMUEL A. BROWN** Vice Dean and Sec'y

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REQUIREMENTS FOR ADMISSION—Candidates must have successfully completed the work prescribed for the Freshman and Sophomore Classes in colleges recognized by this University, which must include at least one year of college work in Physics, General Biology or Zoology and Chemistry (Qualitative Analysis is required; Organic Chemistry is recommended), together with appropriate laboratory exercises in each of these subjects, and two languages other than English (one of which must be French or German). For detailed information send for catalogue. Certificates from recognized colleges covering these requirements will be accepted in place of an examination.

GRADUATE WORK—To properly prepared men (Bachelor's degree required) certain of the subjects of the Medical School are open for election in work in the Graduate School of the University, leading to the Master's Degree or to the degree of Doctor of Philosophy. For graduate physicians having had a preliminary education similar to that required for admission to the Medical School, courses in Public Hygiene, leading to the degree of Doctor of Public Hygiene (Dr.P.H.) are open; or to other persons with adequate preparation parts of this instruction are offered without reference to degree. Courses in Tropical Medicine are conducted from the beginning of the session to about Feb. 1st. The clinics and laboratories are open throughout the year. For further information apply to **Dean of School of Medicine, University of Pennsylvania, Philadelphia**

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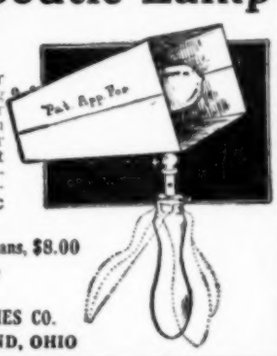

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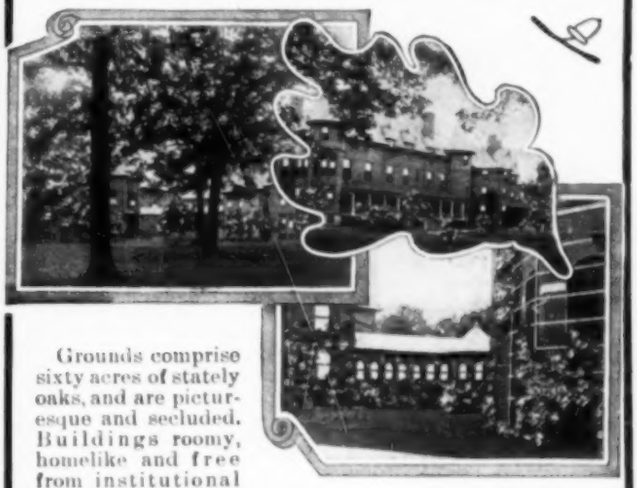

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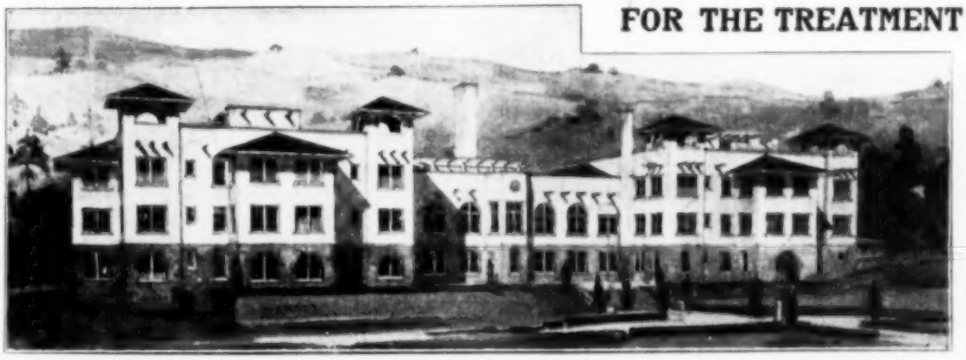

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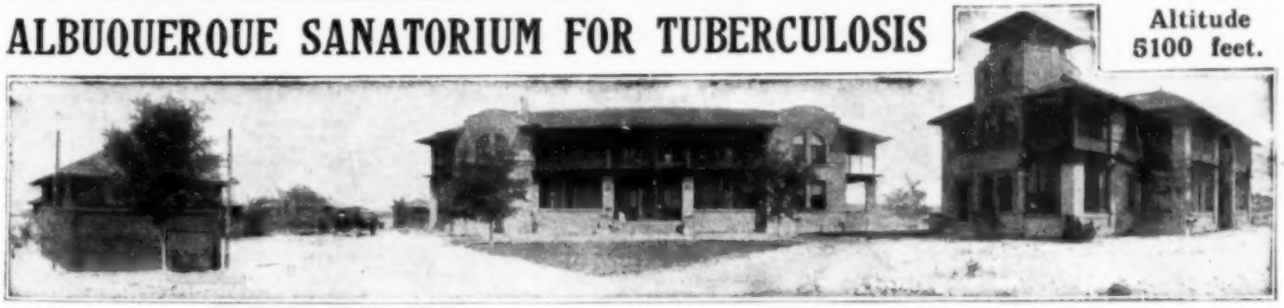

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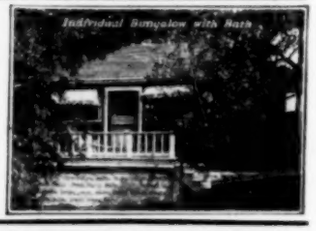

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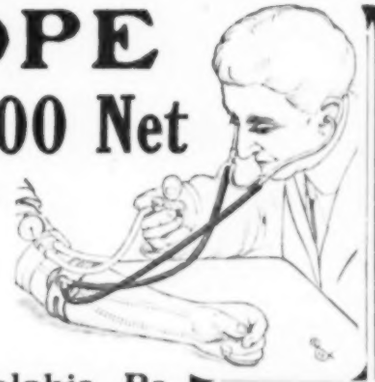

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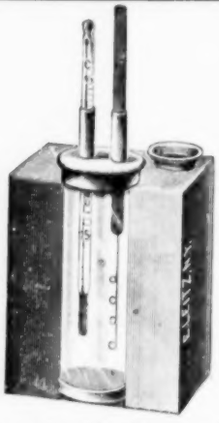

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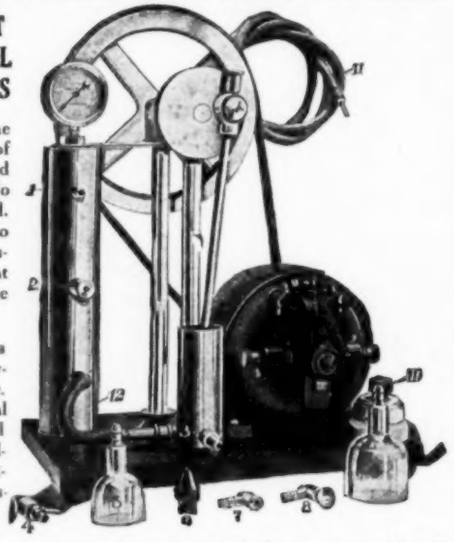

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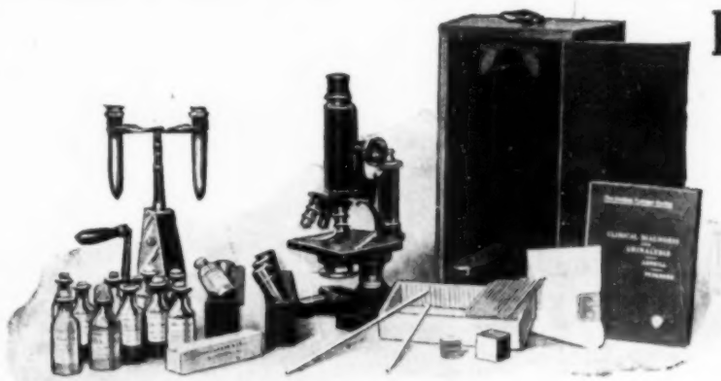

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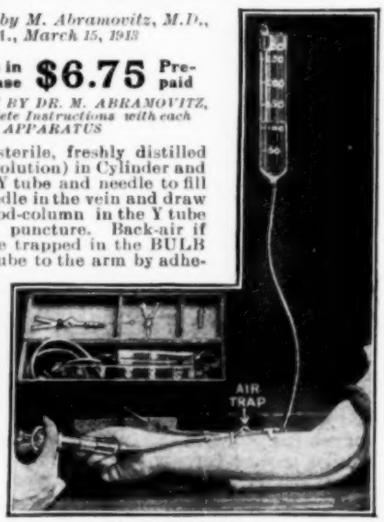

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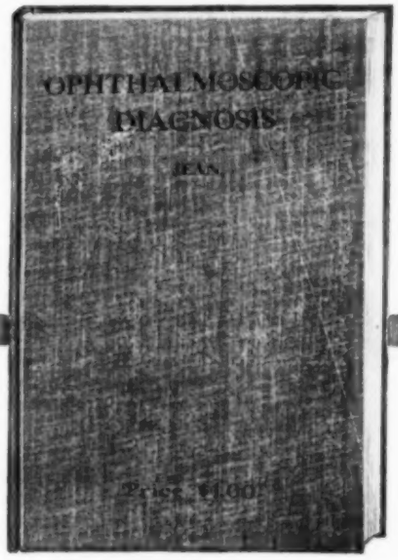

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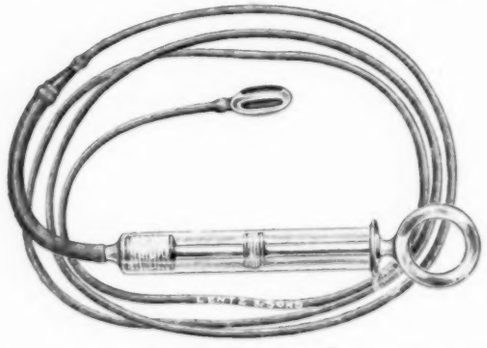

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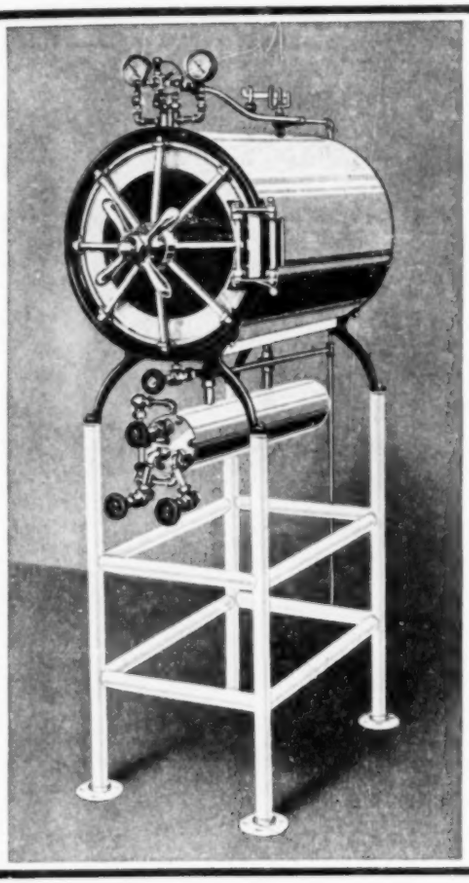

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